

# NC DPS JUVENILE JUSTICE/JCPC REFERRAL FORM

(Please print or type)

<b>Date of Referral:</b>	- - (MM – DD – YYYY)	<b>NC-JOIN ID:</b>	
<b>Program:</b>		<b>County:</b>	

<b>Client Name:</b>		<b>DOB:</b>		<b>SSN:</b>	xxx-xx-	<b>Gender:</b>	M <input type="checkbox"/> F <input type="checkbox"/>
Hispanic/Latino <input type="checkbox"/>	<b>Race:</b>			<b>School/Grade:</b>			
<b>Legal Guardian:</b>				<b>Phone:</b>			
Legal Guardian's relationship to client:							
<b>Physical Address:</b>		<b>City:</b>		<b>Zip:</b>			
<b>Mailing Address:</b>		<b>City:</b>		<b>Zip:</b>			

<b>Is there Juvenile Justice Involvement?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is participation in this program court ordered?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is participation in this program a part of a diversion plan/contract?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>Court Counselor:</b>	<b>Phone:</b>	<b>Email:</b>
<b>Client Risk Score/Level:</b>	<b>Client Needs Score/Level:</b>	

<b>Current Legal Status:</b>	<b>Problem Behaviors \ Risk Indicators:</b>		
<input type="checkbox"/> NA/No Juvenile Justice Involvement <input type="checkbox"/> Court Counselor Consultation <input type="checkbox"/> Diversion Plan/Contract <input type="checkbox"/> Petition Filed <input type="checkbox"/> Deferred Prosecution <input type="checkbox"/> Adjudicated Undisciplined Disposition Pending <input type="checkbox"/> Adjudicated Delinquent Disposition Pending <input type="checkbox"/> Protective Supervision <input type="checkbox"/> Probation <input type="checkbox"/> Commitment <input type="checkbox"/> Post Release Supervision <input type="checkbox"/> Continuation Services	<u><b>INDIVIDUAL</b></u> <input type="checkbox"/> Bullying Behavior <input type="checkbox"/> Negative Labeling/Bullied <input type="checkbox"/> Crime/Delinquency (unreported & reported) <input type="checkbox"/> Fighting/Assault/Aggressive Behavior <input type="checkbox"/> Fire Setting <input type="checkbox"/> Impulsive/Risk Taking <input type="checkbox"/> Mental Health Issues/Depression/Anxiety/Temper Tantrums <input type="checkbox"/> Poor Social Skills/Anti-social <input type="checkbox"/> Run Away from Home <input type="checkbox"/> Self-Mutilation <input type="checkbox"/> Sexually Active <input type="checkbox"/> Sexual Offense <input type="checkbox"/> Sexual/Physical/Mental Abuse/ Victimization/ Trauma	<u><b>INDIVIDUAL (continued)</b></u> <input type="checkbox"/> Substance Use (alcohol or drugs) <input type="checkbox"/> Suicide Attempts <input type="checkbox"/> Suicidal Ideation/Threats <u><b>FAMILY</b></u> <input type="checkbox"/> Excessive Dependence on Parents <input type="checkbox"/> Family Conflict <input type="checkbox"/> Lack of Discipline by Parent or Child is Ungovernable <input type="checkbox"/> Siblings or Parent/Guardian on Probation or Incarcerated <input type="checkbox"/> Substance Use in Home <u><b>SCHOOL</b></u> <input type="checkbox"/> Academic Failure/Behind Grade Level for Age <input type="checkbox"/> Behavior Problems: Disruptive in Class/ Referrals to Office/ Suspensions	<u><b>SCHOOL (continued)</b></u> <input type="checkbox"/> Truancy/Skipping School <u><b>PEER</b></u> <input type="checkbox"/> Gang Associate or Member; or Gang Involvement <input type="checkbox"/> Negative Peer Associations/ Association with Aggressive Peers <input type="checkbox"/> Typically Associates with Negative Older Persons <u><b>COMMUNITY</b></u> <input type="checkbox"/> Availability or Perceived Access to Drugs <input type="checkbox"/> Disadvantaged/ Disorganized/ Impoverished Neighborhood <input type="checkbox"/> Feeling Unsafe in Home Neighborhood <input type="checkbox"/> High Crime Rate in Home Neighborhood

**Additional Client Information:**

Does the client speak English?	Yes <input type="checkbox"/> No <input type="checkbox"/>	What is the primary language spoken in the household?	
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Does the client have an Exceptional Designation (EC or IEP)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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List any current medical problems:	
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List all current medications:	
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Does client have private medical insurance?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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Does client have Medicaid/ Health Choice?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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If "No," has parent/guardian applied for Medicaid or Health Choice?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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**Enter the number of problems the client has experienced over the previous 12 months:**

Number of Runaways		<input type="checkbox"/> Unknown
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Number of Short-Term Suspensions		<input type="checkbox"/> Unknown
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Number of Long-Term Suspensions		<input type="checkbox"/> Unknown
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Number of Expulsions		<input type="checkbox"/> Unknown
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**Additional Comments:**

<b>Name of Person Making Referral:</b>	
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<b>Title:</b>	
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<b>Phone:</b>	
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<b>Email:</b>	
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<b>Describe the reason you're referring this client to this Program:</b>	
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<b>Date Referral Received by Program:</b>	- - (MM - DD - YYYY)
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