

NC DPS JUVENILE JUSTICE/JCPC REFERRAL FORM

(Please print or type)

Date of Referral:	- - (MM - DD - YYYY)	NC-JOIN ID:	
Program:		County:	

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

Is there Juvenile Justice Involvement?	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"/>

Court Counselor:		Phone:		Email:	
Client Risk Score/Level:		Client Needs Score/Level:			

Current Legal Status:	Problem Behaviors \ Risk Indicators:		
<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>INDIVIDUAL</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>INDIVIDUAL (continued)</u> <input type="checkbox"/> Substance Use (alcohol or drugs) <input type="checkbox"/> Suicide Attempts <input type="checkbox"/> Suicidal Ideation/Threats <u>FAMILY</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>SCHOOL</u> <input type="checkbox"/> Academic Failure/Behind Grade Level for Age <input type="checkbox"/> Behavior Problems: Disruptive in Class/ Referrals to Office/ Suspensions	<u>SCHOOL (continued)</u> <input type="checkbox"/> Truancy/Skipping School <u>PEER</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>COMMUNITY</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 No What is the primary language spoken in the household?Does the client have an Exceptional Designation (EC or IEP)? Yes No

List any current medical problems:

List all current medications:

Does client have private medical insurance? Yes No Does client have Medicaid/ Health Choice? Yes No If "No," has parent/guardian applied for Medicaid or Health Choice? Yes No **Enter the number of problems the client has experienced over the previous 12 months:**Number of Runaways UnknownNumber of Short-Term Suspensions UnknownNumber of Long-Term Suspensions UnknownNumber of Expulsions Unknown**Additional Comments:****Name of Person Making Referral:****Title:****Phone:****Email:****Describe the reason you're referring this client to this Program:****Date Referral Received by Program:** - - (MM - DD - YYYY)