CHEROKEE HOME FOR CHILDREN

**Referral Screening Questionnaire**

Click or tap to enter a date.

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| Your Name: |       | Name of Youth:  |       |
| Relationship to Youth: |       | Youth Age: |       |
| Address: street |       | Sex: |  [ ]  Male [ ]  Female |
|  city ,state,zip |      ,     ,      | Number of siblings? |       |
| Phone: |    -   -     | Grade: |    |
| Email: |       | #1 Presenting Problem: |       |
| Minimum of 12 Months? |  [ ]  Yes [ ]  No | Does the youth desire placement? |  [ ]  Yes [ ]  No |

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| **Please briefly explain all “Yes” answers to the questions below.** |
| **Does the Youth have a history of:** | **Yes** | **No** | **Comments** |
| Gang or Cult participation? | [ ]  | [ ]  |       |
| Associates with negative friends? | [ ]  | [ ]  |       |
| Cruelty to animals?  | [ ]  | [ ]  |       |
| Carrying or using weapons?  | [ ]  | [ ]  |       |
| Verbal and/or physical aggression? | [ ]  | [ ]  |       |
| What does youth do when angry or stressed? | [ ]  | [ ]  |       |
| Injuries or medical problems?  | [ ]  | [ ]  |       |
| Taking Medications?  | [ ]  | [ ]  |       |
| Alcohol or drug abuse or dependency? | [ ]  | [ ]  | If “Yes”, list meds taken/drugs abused.       |
| Sexual, physical or emotional abuse? CPS involvement?  | [ ]  | [ ]  | If “Yes”, by who, age began and ended? Abuse confirmed?       |
| Sexually offending or acting out? | [ ]  | [ ]  |       |
| Setting fires/fascination with fires? | [ ]  | [ ]  |       |
| Suicide attempts/thoughts? | [ ]  | [ ]  | If “Yes”, list dates, how attempted.       |
| Family history of mental illness? | [ ]  | [ ]  |       |
| Referred to juvenile detention? | [ ]  | [ ]  |       |
| Involvement with police? | [ ]  | [ ]  | If “Yes”, list all dates, offenses/dispositions.       |
| Stealing? | [ ]  | [ ]  |       |
| Lying? | [ ]  | [ ]  |       |
| Prior placements with family or institutions? | [ ]  | [ ]  | If “Yes”, list all placements and outcomes.       |
| Parents having multiple partners? | [ ]  | [ ]  |       |
| Disciplinary problems at school? | [ ]  | [ ]  | If “Yes”, list expulsions, ISS/alternative school. Etc…       |
| Special Education needs? | [ ]  | [ ]  |       |
| Poor academic performance? | [ ]  | [ ]  |       |
| Truancy? | [ ]  | [ ]  |       |
| Siblings? Relationships with them? | [ ]  | [ ]  |       |

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| **OFFICE USE ONLY** |

Estimated LOC? [ ]  BASIC [ ]  MODERATE [ ]  SPECIALIZED [ ]  INTENSE
Appropriate referral to CHC? [ ]  YES [ ]  NO
If “Yes”, send referral packet by: [ ]  Mail [ ]  E-Mail [ ]  Fax

Application Requested: [ ] Yes [ ]  No
Application sent on : Click or tap to enter a date.

Received back in office on : \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Notes: