F.I.R.S.T.
Families In Recovery to Stay Together
Helping families heal and reunite

REFERRAL FORM

Name:	**Address:**			**Phone #:**
Today's Date & Time:	**City**	**State:**	**Zip:**	**Person making referral:**

1. **Date of Birth:** _____ Age: _____
2. **SS#:**
3. **Sex:** ☐ Male or ☐ Female
4. **Are you a Veteran?** ☐ Yes ☐ No
5. **Are you Pregnant?** ☐ Yes ☐ No
   If yes, how many weeks? Due Date:
6. **Do you smoke cigaretts?** ☐ Yes ☐ No
   If yes, how many per day?

7. **Are you of Hispanic, Latino or Spanish Origin?** ☐ Yes ☐ No
8. **Which of these groups best describe you?**
   - ☐ African American/Black
   - ☐ White/Anglo/Caucasian
   - ☐ Multiracial
   - ☐ American Indian/Native American
   - ☐ Alaskan Native
   - ☐ Asian/Pacifi Islander
   - ☐ Hispanic
   - ☐ Other
9. **Marital Status:** ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living as Married ☐ Never been Married
10. **Living Situation:** ☐ Permanent ☐ Transitional or ☐ Homeless (In a shelter, on the street, in a vehicle)
11. **During the past 3 months, were you working full-time or part-time,** seeking work or not seeking work?
    ☐ Full-time ☐ Part-time ☐ Seeking work ☐ Not seeking work
    Where: _____ Hours: _____
12. **What is the highest grade you completed or degree you received in school?**
    - ☐ 0-12 (no degree) Highest grade completed? ☐
    - ☐ HS diploma / GED
    - ☐ Some college or tech. School ☐ College Degree

13. **Do you have custody of all, some, or none of your children?**
    ☐ All ☐ Some ☐ None
14. **Are you seeking custody of all, some or none of your children?**
    ☐ All ☐ Some ☐ None
15. **How many children are you currently involved with** Child Protecive Services? _____
    One Child's Full Name: _____
16. **Have you had your perental rights terminated before?**
    ☐ Yes ☐ No

For QSAP Only:

Screening Referral Outcome: (check one)

☐ Accepted screening ☐ Refused screening ☐ No show

Screening Date: _____ \ _____ \ _____ Time: _____ : _____

17. **Are you being referred for a screening after:**
    ☐ 7-day ☐ Adjudication or ☐ Review Hearing
    Next Hearing Date: _____ \ _____ \ _____
    Time: _____ : _____
18. **Name of Judge:** _____
19. **Name of Client's Attorney:** _____
20. **Name of Social Worker:** _____
    Phone #: _____
21. **YFS Case #:** C _____ Petition #: J _____
22. **Are you taking any medications?** ☐ Yes ☐ No
    If yes, please list all: _____
23. **Have you ever received inpatient or out patient treatment for Mental Health?** ☐ Yes ☐ No
    If yes, where and when: _____
24. **Drugs recently (last year) used?** ***(Mark all that apply)***
    ☐ Alcohol ☐ Cocaine ☐ Heroin ☐ Marijuana ☐ Other: _____
    Date you last used: _____ \ _____ \ _____
    Substance: _____
25. **Have you ever used a needle to get any dr injected under your skin, into a muscle, or into a wein for non-medical reasons?**
    ☐ Yes ☐ No
26. **Have you ever received inpatien or outpatient treatment for alcohol or other drug abuse** (excluding participation in AA, NA or CA)?
    ☐ Yes ☐ No
    If yes, where and when: _____
27. Do you have insurance? ☐ Yes ☐ No
    Insurance Company: _____
28. Medicaid eligible? ☐ Yes ☐ No
    Medicaid #: _____
29. Household Income: $ _____ # of dependents _____
30. Emergency Contact Name: _____
31. Emergency Contact Number: _____

Other Relevant Info. (i.e. pending criminal charges, medical conditions):

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