801 S Kettle St **FACE IT**

Altoona PA, 16602 **Program**

Office #: (814) 201-2751

FACE IT on call- #1- RED PHONE- (814) 931-7835

#2- BLACK PHONE- (814) 931-7842

*\*Please send referrals to: Hannah Domaradzki, MA, NCC*

FACE IT Program Director

Email: hdomaradzki@evolutionblair.com

Cell #: (814) 515-9630 Fax #: (814) 201-2758

| **DATE OF REFERRAL** | **FACE IT On-call Outreach** | | **Date of On-Call Outreach**  **(if applicable)** | |
| --- | --- | --- | --- | --- |
|  | ☐ YES ☐ NO | |  | |
| **COMMUNITY PARTNER** | | **PREFERRED COMMUNICATION** | | **PREFERRED CONTACT INFO** |
| Name: | | CELL / OFFICE PHONE / EMAIL | |  |
| Agency/Department and Position: | | | | |
| **CYF/JPO ASSIGNED STAFF**  **(if applicable)** | | **PREFERRED COMMUNICATION** | | **PREFERRED CONTACT INFO** |
|  | | CELL / OFFICE PHONE / EMAIL | |  |

| **PRIMARY ADOLESCENT** | | |
| --- | --- | --- |
| **FULL NAME** | **DOB/ AGE** | **SSN** |
|  |  |  |
| **CIRCLE ONE: MALE/ FEMALE/ OTHER** |  | |
| **STREET ADDRESS** | **CITY, STATE and ZIP CODE** | |
|  |  | |
| **EMAIL ADDRESS** | **HOME PHONE** | **CELL PHONE** |
|  |  |  |
| Who has legal custody of the adolescent? |  | |
| Where does the adolescent currently reside? |  | |

| **REASON FOR REFERRAL (\*Describe removal or risk of removal from natural environment)** | | |
| --- | --- | --- |
|  | | |
| **ADOLESCENT & FAMILY STRENGTHS** | | |
|  | | |
| **SERVICES CURRENTLY INVOLVED IN FAMILY** | | |
|  | | |
| **MENTAL HEALTH DIAGNOSIS** | | |
| Explanation: | | |
| Medication: | | |
| **SCHOOL INFORMATION** | | |
| School attending:  Current grade: | | |
| **FAMILY & HOUSEHOLD** | | |
| **Mother / Female Guardian Name** | **Relationship** | **Age** |
|  |  |  |
| History of substance abuse, violence, or mental health involvement? |  | |
| **Father / Male Guardian Name** | **Relationship** | **Age** |
|  |  |  |
| History of substance abuse, violence, or mental health involvement? |  | |
| **Number of siblings living in home** | **Other key supports** | |
|  |  | |

**NEXT SECTION ONLY TO BE COMPLETED BY CYF/ JPO STAFF.**

| **CYF/ JPO STAFF REVIEWER** | **PREFERRED COMMUNICATION** | | **PREFERRED CONTACT INFO** |
| --- | --- | --- | --- |
| Name: | CELL/ OFFICE PHONE/ EMAIL | |  |
| **DATE and OUTCOME OF REFERRAL REVIEW** | | **FURTHER REVIEW NECESSARY?** | |
| Date of review:  ☐ Approved for FACE IT ☐ Denied | | ☐ YES ☐ NO | |

\* If a meeting is needed to review referral in more detail, please contact Hannah or Jeff Colbert at Evolution and we will collaborate with the original Community Partner to request and schedule a meeting. Please forward all decisions to: *Hannah Domaradzki, MA, NCC - Program Director*/ Email: hdomaradzki@evolutionblair.com