# Youth (Female) Mentoring Referral Form

**Community Action for Capable Youth**
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Mansfield, OH 44906
Phone: 419-774-5683/ Fax: 419-774-6364
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CACY

All information included on this form will be kept confidential and is for agency use only.

**Please print clearly or type all information.**

## Referral Source Information

| | |
|---|---|
| Referral Date: | Referral Agency: |
| Phone Number: | Email: |
| Name/ Title of Referral Source: | |
| Signature of Referral Source: | |

## Youth Information

| | | |
|---|---|---|
| Name: | DOB: | Age: |
| Gender: | Race: ☐White ☐African American ☐Hispanic ☐Other _____ | |
| Suggested times to meet with youth: ☐Weekdays ☐Lunchtime ☐Afterschool ☐ Evenings | | |
| Parent/ Guardian Name: | Relationship to Youth: | |
| Best time of day to reach caregiver: | Caregiver Employer: | |
| Street Address: | | |
| City: | State: | Zip: |
| Contact # (Guardian): | Contact # (Youth): | |
| Parents names if guardian is different: Mother | Father | |
| Please list all members in the household: | | |

| Name | Age | Gender | Relationship to Youth |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

| |
|---|
| Does youth have any physical limitations or restrictions? If yes, please specify: |
| Does youth currently take medication? If yes, type: |
| Any known allergies? If yes, please list any: |

**Education**

| | |
|---|---|
| School Attends: | Current Grade Level: |
| Academic Progress on track: ☐Yes ☐No | Current IEP (Individual Education Plan): ☐Yes ☐No |
| Educational Areas of Concern (Check all that apply): ☐Math ☐Science ☐Reading/ Writing ☐Other | |
| Any other important information: | |

**Reasons for Referral**

| | | | |
|---|---|---|---|
| Youth is being referred for CACY mentoring due to the following reasons (Check all that apply): | | | |
| ☐Academic Issues | ☐Behavioral Issues | ☐Study Habits | ☐Social Issues |
| ☐Delinquent Activities | ☐Family Concerns | ☐Bullying | ☐ATOD Use/ Risky Behaviors |
| Is youth currently seeing a mental health counselor? ☐Yes ☐No | | | |
| Counseling Organization: | | Name of Counselor: | |
| List any major traumatic events in child's life (examples, death of parent/sibling, abuse, foster care, etc.): | | | |

**Youth's Interests**

| | | | | |
|---|---|---|---|---|
| Check all that apply: | | | | |
| ☐Music | ☐Cooking | ☐Reading | ☐Outdoor/ Nature | ☐Animals |
| ☐Crafts/ Art | ☐Games | ☐Social/ People | ☐Hair/ Makeup | ☐Sports |
| Other: | | | | |
| Clubs or group currently involved with (in or out of school): | | | | |
| Does youth have difficulty making friends? ☐ Yes ☐ No | | | | |
| Please list any other information which will be helpful to Mentor to deliver quality services: | | | | |