Elite Youth & Family Services
Referral/Admission Form/Face Sheet

REFERRAL INFORMATION:

Client Name: _____ Referral Date: _____

Client Address: _____ Client Phone: _____

Directions: _____ Race/Ethnicity: _____

Parent/Guardian name: _____ Alternate Phone #:_____

CPS/TSS Involved: ☐ yes ☐ no, If yes, name and phone # of CM: _____

Client CIS ID#: _____ Client SS Number: _____

Client Date of Birth: _____ AHCCCS ID #: _____

Gender: _____ Age _____ Preferred Language: _____

Diagnosis Code(s):_____ Tribal Affiliation: _____

Special Needs: _____ yes _____ no If yes please specify:_____

Client allergies/medical conditions: _____

Medications: _____

Emergency Contact: _____

Emergency Contact phone: _____

PCP Name: _____ PCP Phone #: _____ _____

Presenting Problem(s): _____

SERVICES REQUESTED:

- ☐ **Mentor: Female/Male**
- ☐ **LGBTQ Mentoring Services**
- ☐ **LEAD Job Development Program**
- ☐ **Mentor/Behavior Coach**
- ☐ **Parenting Skills**
- ☐ **Transitional Living Housing Program**
- ☐ **Home/Community Based Counseling**
- ☐ **Family Support Services**
- ☐ **Peer Support Program**
- ☐ **Educational/GED/Online Academic assistance**
- ☐ **Elite Youth & Empowerment Program**

Clinical Liaison Name/Signature: _____

Clinical Liaison Office phone number: _____ Ext.: _____ Cell Phone: _____

Special Instructions/Additional information or instructions. _____

Please include the following documents: ☐ EYFS Referral Sheet ☐ Signed Comprehensive Assessment ☐ [RBHA ISP Signed ☐ AHCCCS Eligibility Verification Form

******Please send referrals to: eliteyfs1@gmail.com**

Please contact Antoinette M. Wells for any questions and/or concerns at 480.628.5339 or eliteyfs1@gmail.com.

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