Thrive Program Referral Form

Date (d/m/y): _____

Name:	D.O.B. (d/m/y):	Age:	Gender:
Phone Number:	Alternate Number:		
MCP #:	SIN #:		
Is the youth aware of the referral?	**Yes**	**No**	

If possible please complete this form with the young person.

Please complete as much of this form as you know.

Living Arrangement

Name(s):	Relationship to Youth:
Street Address:	Postal Code:
Phone Number:	Alternate Number:

Program Applying For

	x	Comments
Velocity		
Youth at Promise (YAP)		
GED		

Reason for Referral

_____

_____

_____

_____

_____

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Education Status

	No	Yes	Comments
Attending regular school?			
Attending alternative learning?			
Dropped out of school?			
Has the youth ever been suspended?			
Current grade level or highest completed?			
Current school or last attended			

Please check off the level at which you think you are reading/writing and doing math:

	Primary (K-3)	Elementary (4-6)	Jr High (7-9)	High School (10-12)
Reading				
Writing				
Math				

Have you been socially promoted or pushed ahead a grade in school? **Yes** **No**

Have there been any educational assessments completed by the school on you? **Yes** **No**
Describe any learning challenges identified or not identified: _____
_____
_____
_____

Have you ever had any psychological assessments completed? **Yes** **No**
If yes, please explain. _____
_____
_____
_____

Please list your strengths:_____
_____
_____
_____

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What are some of your interests (e.g., sports, art, music, cards, collecting, juggling, etc…)?

_____

_____

_____

Substance Use/Abuse

	Yes	No	Sometimes
Illegal Drugs			
Weed			
Alcohol			
How would you describe your use?	**Many times a day**	**Once a day**	**Occasional**

Behaviour/Attitudes

Do you get into fights or yell at people?	Yes	No	Unsure
If yes, please describe:			

Relationships

	Poor	Fair	Good	Unsure
Relationship with Family				
Relationship with Peers				
Involvement in Community Activities				

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Supports

	Name	Contact Info
Social Worker		
Child Youth and Family Services		
Corrections		
Addictions		
Housing Support		
Counselling/Psychology		
Community		
Other Education Support		
Other		

Income (please circle the one that applies to you):

Youth Services **Working/Self-supported** **AES**

Living with Family **Living with Family on AES**

Other Supports (circle which supports you might need help accessing):

Transportation **Childcare** **Job/Career Planning**

Medical information

	Name	Contact Info
Family Doctor		
Other		
Medical conditions and medications it would be helpful for us to know about:		

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Referral Information

Name:	Bus. Phone:	Alternate Phone:
Email:		Fax Number:
Mailing Address:	City:	Postal Code:

Completed Referral Forms can be returned to us my email, fax, or mail.

Email: ejones@thrivecyn.ca Fax: 709-754-0842 Phone: 709-754-0536 ext. 210

Mail: Thrive CYN PO Box 26067 St. John's, NL A1E 0A5

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Date (d/m/y): _____

Consent for Data Collection

I, _____, give Thrive, CYN, permission to add me to or access the Arms database through my SIN number or other identifying client ID.

Signature (Youth): _____ Signature (Staff): _____

Date (d/m/y): _____

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Date (d/m/y): _____

Consent to obtain/release information

I _____ give my permission and consent of my own free will for the gathering/release of information relating to my involvement in and community connections made through **Thrive Programs**.

Thrive staff person(s) is/are granted permission to obtain information from the following organization(s) and/or staff person(s):

Organization	Staff Person(s)

This consent is valid for one year from: _____ to _____

_____ _____

Signature of youth Date (d/m/y)

_____ _____

Signature of Parent/Caregiver Date (d/m/y)

_____ _____

Witness Date (d/m/y)