THE UNIVERSITY OF ALABAMA® | School of Social Work

Youth Services Institute
Continuum of Care Program (COCP)
P.O. Box 870316
Tuscaloosa, Alabama 35487-0316
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REFERRAL FORM

Date of Referral: _____

Referral Source: _____ **County:** _____

Contact Info (Phone #, Email address): _____

Client's Name (First, Middle & Last): _____

Date of Birth: _____ **Race:** _____ **Sex:** _____

Parent/Guardian: _____ **Contact Phone Number:** _____

Other agency involvement/purpose (i.e., DHR, Mental Health): _____

Service Requested:

- ☐ **Aftercare Treatment**
- ☐ **CASP**
- ☐ **Comprehensive Assessment to determine treatment need and/or level of risk**
- ☐ **Other**

Current Case Status:
JU Numbers: _____

Pending Charges Filed (please specify): _____

Post Adjudication Charge: _____

- ☐ **Pre-adjudication**
- ☐ **Post-adjudication/pre-sentencing**
- ☐ **No charges filed** (please specify: ☐ none anticipated ☐ pending assessment)

Please list all court dates/purpose pertinent to this case:

_____

_____

Other relevant action taken to date:

_____

_____

***REQUEST MUST BE ACCOMPANIED BY SUPPORTING DOCUMENTS FOR CONSIDERATION, to include petitions, client's legal history, case action summary, arrest/offense report, narrative summaries of statements, pertinent court orders. If client has no legal system involvements, a narrative summary detailing the reason for the referral is required.**