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Liaison P.O.: _____ Date Received: _____ Approved Not Approved
Comments: _____

This referral is being directed to: _____
NAME OF PROGRAM

NAME OF YOUTH PHONE BC MEDICAL # BIRTH DATE (YY/MM/DD) AGE
ADDRESS CITY POSTAL CODE
GENDER Male Female ETHNIC ORIGIN ABORIGINAL STATUS NUMBER (IF APPLICABLE)
HEIGHT WEIGHT HAIR EYE COLOUR BUILD

YOUTH'S CONTACTS INFORMATION

PARENT/GUARDIAN

NAME HOME PHONE WORK PHONE
ADDRESS CITY POSTAL CODE

Is the youth a "Child in Care" (CIC) as defined by the Child, Family and Community Service Act? NO YES If yes, please specify: _____

SOCIAL WORKER (if CIC)

SOCIAL WORKER NAME WORK PHONE FAX

EMERGENCY CONTACT

NAME RELATIONSHIP PHONE

MEDICAL CONTACT(S)

FAMILY PHYSICIAN NAME WORK PHONE DENTIST NAME WORK PHONE

REFERRING PROBATION OFFICER

NAME WORK PHONE FAX
OFFICE ADDRESS CITY POSTAL CODE

YOUTH'S BEHAVIOUR

Does the youth display any of the following behaviours:

	No	Yes	Unknown
Running away?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostitution?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self mutilation/harm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse? (if yes, identify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical aggressiveness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Verbally abusive to others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fire setting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual inappropriate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

YCRNA RESULTS: Low Medium High

Specifics: _____

COURT BACKGROUND:

How old was the youth on his/her first offence?

Under 13 years 13-15 years 16-18 years

The youth's court history includes (check all that apply):

Arson Assault Drug Offence Failure to Comply Property Sex Offence
 Weapons Other (please identify): _____

Details

	No	Yes	Court date
Does the youth have any outstanding charges? (if yes, explain below)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is this youth currently in custody?	<input type="checkbox"/>	<input type="checkbox"/>	YY/MM/DD
Is this youth currently on remand?	<input type="checkbox"/>	<input type="checkbox"/>	
Has this youth ever been in custody?	<input type="checkbox"/>	<input type="checkbox"/>	

Comments: _____

Does the youth have any of the following outstanding?	No	Yes	
Fines	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Compensation/Restitution	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Community Service Hours	<input type="checkbox"/>	<input type="checkbox"/>	# _____
Letter of Apology	<input type="checkbox"/>	<input type="checkbox"/>	Due Date _____
Essay	<input type="checkbox"/>	<input type="checkbox"/>	Due Date _____

Notes:

FAMILY ENVIRONMENT

With whom does the youth presently reside?

- Natural Family (both parents) Group Home Blended Family Single Parent
 Foster Family Adoptive Family Other Family Independent Living/Youth Agreement

Comments: _____

With whom will the youth reside upon graduation of the program?

- Same as above Other _____

Describe release plan (residence, school, counselling, etc.):

Parent/Youth Relations:

	No	Yes	Unknown
Neglect of the youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent/Youth communication problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent overly protective	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of excessive/strict discipline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parents cover for youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Permissive parenting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problem(s) involving step-parent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inconsistent use of discipline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical fights between youth and parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual abuse concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you discussed this referral with the youth?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you discussed this referral with the youth's family?	<input type="checkbox"/>	<input type="checkbox"/>	
Has transportation to the program been arranged?	<input type="checkbox"/>	<input type="checkbox"/>	

Has the youth been diagnosed with any of the following:

	No	Yes	Unknown
ADHD (Attention Deficit Hyperactivity Disorder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADD (Attention Deficit Disorder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RAD (Reactive Attachment Disorder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FASD (Fetal Alcohol Spectrum Disorder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OCD (Obsessive Compulsive Disorder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oppositionally Defiant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

EDUCATION

Is the youth currently enrolled in school? No Yes

Current or last school attended: _____

Phone #: () _____ Fax #: () _____

Last grade completed: _____ Year: _____

Have any formal education or learning difficulties assessments been completed on this youth? (if yes please attach):

No

Yes

Can the youth return to school after graduating from the program? No Yes

EMPLOYMENT HISTORY

Describe:

HAVE YOU ATTACHED?

	No	Yes
Pre-Sentence Report	<input type="checkbox"/>	<input type="checkbox"/>
Court Order	<input type="checkbox"/>	<input type="checkbox"/>

Goals of referral program (attach additional pages if you require more space):

Referring PO Signature: _____ Date Signed: _____

YY/MM/DD