SANCTUARY

406 Mai Mai Road Chalan Pago, GU 96910

www.sanctuaryguam.com | sanctuary@westcare.com

TEL: (671) 475-7101 * 24hr Crisis (671) 475-7100

YOUTH REFERRAL FORM

Youth Information

Last Name		First Name		M.I.:
Social Security Number:	Date of Birth:	Age:	Last School Attended / Grade	
Race:	Interpreter Services needed: ☐ Yes ☐ No	If yes, in what language:		
Residential Address:	City:	State:	Zip Code:	

Parent/Legal Guardian Information

Last Name		First Name	M.I.:
Home Phone:	Cell Phone:	Work Phone	E-mail Address:
Race:	Relationship to youth	Interpreter Services needed: ☐ Yes ☐ No If yes, in what language:	
Residential Address:	City:	State:	Zip Code:
Mailing Address: (If different than residential)	City:	State:	Zip Code:

Referral Source Information:

Last Name		First Name	M.I.:
Home Phone:	Cell Phone:	Work Phone	E-mail Address:
Agency Name (if, any)		Relationship to youth:	

Reason for Referral/Services Requested:

Youth is recommended for the following (check mark one or more that apply):

☐ COED Emergency Shelter

☐ Drug & Alcohol Screening (Service results will identify appropriate level of care for either Outpatient / Intensive Outpatient / Inpatient (Sagan Na'homlo')

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History of Services:

Has the youth previously or currently receiving services from the following: (Complete all that apply)

CPS Involvement Yes ☐ No ☐	Assigned Social Worker:	Reason for Involvement:
DYA Yes ☐ No ☐	Assigned Social Worker:	Is the minor currently in DYA? Yes ☐ No ☐
GBHWC Yes ☐ No ☐	Medication/Psychiatrist:	Schedule Appointment:
Probation Yes ☐ No ☐	Assigned Probation Officer:	Contact Number:
Other: **(Counseling ie..)**	Name:	Contact Number:

Parent Legal/ Guardian Name ______ **Signature** ______ **Date** ______

Youth Name ______ **Signature** ______ **Date** ______

Referring Agency/Person ______ **Signature** ______ **Date** ______

SANCTUARY ADMINISTRATION USE ONLY

This document was received through (Check Mark One):

□ In-person □ Crisis Phone □ E-mail

Date & Time Received:	**Service Disposition**
Scheduled Appointment Date & Time:	**Disposition of Referral:** ☐ Accepted – Services Initiated ☐ Pending – Awaiting Additional Information ☐ Referred to Another Agency ☐ Declined – Services Not Needed/Not Appropriate ☐ Closed – No Further Action Require

Notes/Comments:

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Staff Completing Disposition:

Name: ______________________________ Title: ______________________

Signature: ___________________________ Date: ______________________