The Neighborhood Center, Inc.

Clinic Child/Adolescent Referral

☐ **Utica: 628 Mary St.**
Utica, NY 13501
315-272-2700

☐ **Rome: 199 W. Dominick St.**
Rome, NY 13440
315-272-2730

Name: _____

DOB: _____ Age: _____ Gender: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Parent/Guardian: _____Date Contacted: _____

Parent/Guardian: _____Date Contacted: _____

Reason for Referral:

☐ Trauma
☐ Risk Taking/High Risk Behaviors
☐ Boundaries and Expectations
☐ Commitment to Learning
☐ Social Competencies
☐ Family Structure i.e. Foster Care, absent parent
☐ Other _____
☐ Support
☐ Empowerment
☐ Constructive Use of Time
☐ Positive Values
☐ Positive Identity

☐ Diagnosed MH _____

Strengths Noted:

☐ Family Support
☐ Positive Peer Support
☐ Self-Identified Need for Services
☐ Other _____

Has the individual received Clinical Services at The Neighborhood Center before?

☐ Yes Last time received services, if known_____
☐ No
☐ Unknown

Referral Source:

Name: _____ Position: _____

Contact Information: _____