YouthDiversion
Essex County Diversion Program

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OUTREACH REFERRAL FORM
ESSEX COUNTY DIVERSION PROGRAM

Date of Referral: _____

Client Information

Youth's Name: _____ _____ _____
Last Name First Name Middle Initial

Address: _____ _____
Street Number Street Name City Province Unit/Apt #

Date Of Birth: _____ _____ _____ Age: ____ Gender:_____ School:_____ Grade:____
Day Month Year

Home Number: _____ Cell Phone Number: _____

Referral Source

- ☐ Self-Referral (Youth)
- ☐ Parent/Family Member
- ☐ School
- ☐ Community Partner
- ☐ Probation
- ☐ Other

Referral Sources Name: _____
School/Agency Referring (If Applicable)_____
Relationship to Youth: _____
Phone Number: _____
Alt #: _____
Email Address: _____

Referral to Programs

Please check all programs that you are referring the youth to:

- ☐ Rebound Life Choices (10 week social skills program)
- ☐ M.E.S.S.A.G.E. (Dangers of social media "Sexting" for females)
- ☐ R.E.S.P.E.C.T (Dangers of social media "Sexting" for males)
- ☐ Beyond Bullying (Understanding the consequences of bullying)
- ☐ Teen Intervene (Early intervention substance abuse program)
- ☐ Substance Abuse Program (12 week cognitive behavioural treatment program)
- ☐ L.O.S.S (Consequences of theft)

Reason For Referral

Please explain the reason for the referral or any concerns you have:

Does this youth have a Youth Court Record or have they been involved with Youth Probation or Youth Justice?

- ☐ Yes
- ☐ No
- ☐ Unknown

Does this youth have any non-associations? If yes please state with whom

Availability

Upon receiving the referral what are the best days and times to contact you?

What are the best days and times to set up an intake with the youth?

Date Referral is Received (Diversion Staff Only):