Mail or Email to:
James River Therapeutic Services
P.O. Box 234 Cumberland, VA 23040
JRTSreports.jamesriver@gmail.com
434-414-4207

Referral Form

APPLICANT – General Information

Name: _____Date of Birth_____

Gender: ☐ F ☐ M ☐ Transgender ☐ Other Identification:_____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: (___) _____Alternative Phone: (___) _____

If the Applicant is a Minor, LEGAL GUARDIAN Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: (___) _____Alternative Phone: (___) _____

Relationship to Youth:

☐ Biological Parent(s) ☐ Biological Relative -_____ ☐ Adoptive Parent(s)

☐ Foster Parents ☐ Social Worker ☐ Other: _____

Primary Phone Number: (___) _____Alternative Phone: (___) _____

Approval to accept text messages on the Primary Phone Number? Yes No

Email: _____

Circle preferred form of communication from us with you:

⊙ Phone Call ⊙ Email ⊙ Text Message

Please answer the following questions as they apply to the Applicant:

If student, Name of School: _____

Grade: _____ Special Education Eligible: Yes No

If employed, Name of Employer: _____

Number of Hours worked per week: _____

Is there any involvement with the court system? Yes No

Probation Officer/ Contact information:_____

_____

If yes, please indicate the criminal charge[s] and/or describe the legal matter[s] causing court involvement: _____

_____

Including Applicant, how many people live in the household? _____

Are there any special circumstances or unique issues about the household we should be aware of in considering services? _____

_____

Name of person making referral: _____

Date Referred: _____

Name of Agency/School: _____

Agency/School Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Secondary Phone: _____

FAX: _____Email: _____

Ability to send and receive scanned documents? Yes No

Requested Services

Please circle the service(s) this referral is being made for:

- € Therapeutic Mentoring
- € Parent/Family Support (CSA funded)
- € Home Based Service
- € Other _____

Funding

Please circle the primary funding sources for the service[s] being requested:

- € CSA
- € Private Pay
- € Other_____

What concerns about the applicant have prompted you to make this referral? Briefly describe:

Please indicate any of the following learning disabilities or behavioral health issues that apply to the applicant:

☐ ADHD/ADD ☐ Oppositional Defiant Disorder/Conduct Disorder ☐ Mood or Anxiety Disorder
☐ Dyslexia/Dyspraxia/Dysgraphia/Dyscalculia ☐ Emotional Disturbance ☐ Substance Use/Abuse
☐ Depressive Disorder ☐ Autism Spectrum Disorders ☐ Trauma and Stressor Related Disorder
☐ Other Disorders or Diagnoses: _____

Areas of needed focus: Please check the appropriate boxes below/ add any comments/concerns:

☐ Social Skills Development

☐ Relationship Skills

☐ Modeling Appropriate Behaviors

☐ Communication Skills

☐ Listening Skills

☐ Personal Appearance and Hygiene

☐ Daily living Skills

☐ Organizational Skills

☐ Responsibility

☐ Conflict Resolution Skills

☐ Problem Solving Skills

☐ Anger Management

☐ Identifying and Verbalizing Feelings

☐ Stress Reduction

☐ Self-Care versus Risky Behaviors

☐ Completing Tasks

☐ Sensitivity & Awareness of Others

OTHER:

☐ Understanding Body Language

☐ Forming Positive Peer Friendships

☐ Finding Creative or Recreational Outlets

☐ Respecting Adult Relationships

☐ Academic Support

☐ Employment Skills / Job Coaching

☐ Character Development

☐ Family Coaching

☐ Support with Parenting skills

☐ Leadership Skills

☐ Basic Money Management

☐ How to Act in Public

☐ Transition Support for Life Stage Changes

☐ Independent Living Skills

☐ Utilizing Technology to Function in Society

☐ How to Access Public Services/Businesses

☐ Linking to Community Support/Services

OTHER: