

P.O. Box 1028
1336 S. Fannin
Columbus, TX 78934

[for INSTRUCTIONS – Click Here](#)

979-732-8355 or 1-800-2567-321

Fax: 979-732-2580

[email: info@ccyfs.org](mailto:info@ccyfs.org)

YOUTH AND FAMILY SERVICES, INC
Promoting Positive and Healthy Individuals and Families
Referral Form (Fill in/Print out)

NAME _____ DATE _____

PARENT/GUARDIAN (if applicable) _____ AWARE OF REFERRAL? yes no

ADDRESS _____

CITY _____ COUNTY _____ ZIP _____

AGE _____ DOB _____ GENDER male female ETHNICITY _____

HOME # _____ WORK # _____

REFERRAL FOR THE FOLLOWING SERVICE(S) – Check all that apply

<input type="checkbox"/> STAR at-risk youth and families: not drug/alcohol related <input type="checkbox"/> Family Conflict <input type="checkbox"/> Runaway <input type="checkbox"/> Truancy <input type="checkbox"/> Delinquent Conduct: ages 7-10 years <input type="checkbox"/> Misdemeanor Offense: Code _____ <input type="checkbox"/> State Jail Felony: Code _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Screening & Assessment for drug and alcohol problems <input type="checkbox"/> Screening and Assessment <input type="checkbox"/> Individual: drug/alcohol education and/or counseling <input type="checkbox"/> Family Member/Partner of Substance Abuse <input type="checkbox"/> Outpatient treatment for youth and adults
<input type="checkbox"/> IDP Integrated Delinquency Prevention program <input type="checkbox"/> Youth and at least one family member STAR counselor _____	<input type="checkbox"/> RPG <input type="checkbox"/> Individual, Adult <input type="checkbox"/> Individual, Youth

REASON FOR REFERRAL: _____

REFERRED BY: _____ PHONE # _____

IF PERSON IS INSTRUCTED TO MAKE CONTACT WITH OUR OFFICE, BY WHAT DATE? _____

RECEIVED BY:

YFS REPRESENTATIVE _____ DATE _____

[SERVICES](#)

[CCYFS LOCATIONS](#)

[EMAIL for INFO](#)

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