EL PASO COUNTY
JUVENILE PROBATION DEPARTMENT
CRISIS INTERVENTION REFERRAL

_____
Date of Referral

Youth's Name: _____

Age: _____ DOB: _____ Sex: _____ JPD#: _____

Address: _____ Phone: _____

School: _____ Grade: _____

Parents/Legal Guardian:

Name: _____ Relationship: _____

Address (if different from above): _____

Home Phone: _____ Work Phone: _____

Insurance Information:

❑ Medicaid # _____ ❑ CHIPS # _____

❑ Private Insurance # _____ ❑ Other _____ # _____

Referred By:

❑ Intake Unit ❑ DP ❑ Conference Committee

❑ Detention ❑ Probation Service ❑ Challenge Aftercare

Presenting Issues:

Level I

❑ Severe Family Conflict ❑ Runaway Episodes
❑ Angry-Irritable-Assaultive ❑ Thought Disturbances
❑ Traumatic Experience ❑ Suicidal thoughts
❑ Family Violence ❑ Other:

***Face-to-Face Contact within 1 hr. after referral is made**

Level II

❑ School Problems
❑ Problems with Juv. Justice
❑ Alcohol/Drug Issues
❑ Other:

*** Face-to-Face Contact and/or via-telephone within 2 hrs. after referral is made**

Comments: _____

_____

_____

_____ _____
Signature **Date**

Contractor Use Only

Contractor shall complete and return/fax to the Juvenile Probation Department within 24 hours of referral.

Services initiated by: _____ Contact: ❑ Yes _____ ❑ No _____
Typed Name Date Attempted Date

Additional Counseling Services needed: ❑ Yes ❑ No

If yes, what type of service: _____

_____ _____
Signature **Date**