Youth Options Shasta

Request for Services / Referral Form

Date:_____

Name of Youth:	DOB:	Grade:	Race/Ethnicity:
Address:			
Parent(s) / Guardian's Name:		Female Head of Household: Yes or No	
Parent(s) / Guardian's Phone / Email Address:		Current or Former Foster Youth:Yes or No	
Reason(s) for Referral:		School Name:	

Check which services you think the youth would benefit from:

_____ Anger Management _____ Peer Court _____ Tobacco Cessation
_____ Project: Towards No Drugs (TND) _____ Bite of Reality: Financial Workshop

Referrer's Name and Title:
Referrer's School / Agency / Relationship to youth:
Referrer's Phone / Email Address:

Please email this form to info@yoshasta.org or fax to 530-244-4150

1700 Pine street, Redding, CA 96001 530-244-7194

www.youthoptionsshasta.com