



Youth Options Shasta

Request for Services / Referral Form

Date: _____

Name of Youth:	DOB:	Grade:	Race/Ethnicity:
Youth's School:		Youth's 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:			
<p>Check which services you think the youth would benefit from:</p> <p> <input type="checkbox"/> Anger Management <input type="checkbox"/> Peer Court <input type="checkbox"/> Tobacco Cessation <input type="checkbox"/> Project: Towards No Drugs (TND) <input type="checkbox"/> Bite of Reality: Financial Workshop </p>			

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

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

www.youthoptionsshasta.com