OPEN ROADS COMMUNITY CENTER
Request for Services Form

Name: ______________________________ **DOB:** ____/____/____ **Age:**_____ **Gender:**______

Guardian's Name: ______________________________ **Relationship to youth:** ______________

Address: ______________________________ **City:** ______________ **Zip Code:** __________

Phone numbers: **Youth:** ______________________ **Caregiver:** ______________________

Emails: **Youth:** ______________________ **Caregiver:** ______________________

Bilingual Provider Required: **Youth:** ☐Yes ☐No **Caregiver:** ☐Yes ☐No **Language:** ______________

REFERRAL REASON(S) & HISTORY OF PRESENTING PROBLEMS (CHECK ALL THAT APPLY)

❐ Anxiety	❐ DDD	❐ Gender Identity	❐ School issues / Truancy
❐ ASD	❐ Defiant/Oppositional	❐ Homicidal ideation	❐ Sleep disorders
❐ Conflict – w/ parents	❐ Depression	❐ Hyperactivity	❐ Suicidal Ideation
❐ Conflict – w/ placement	❐ Eating disorder	❐ Runaway history	❐ Other______________

SERVICE TYPE	CHECK BOX
MENTAL HEALTH	
WORKSHOPS	
GROUP THERAPY	
SOCIAL SERVICES	

REFERRED BY:

AGENCY: ______________________ **FAMILY / FRIEND:**______________________

SCHOOL: ______________________ **COMPANY:**______________________

SOCIAL MEDIA: ______________________ **WEBSITE:**______________________

FOR OFFICE USE ONLY

Referral received on: ____/____/____ **Family contacted on:** ____/____/____

By: ______________________________________