



TOHONO O'ODHAM POLICE DEPARTMENT YOUTH MENTOR PROGRAM

PROJECT ILEAD: Inspiring Leadership, Enrichment and Determination



P.O. Box 189 ☉ Sells, AZ ☉ 85634 ☉ Office: 520-383-4354 ☉ Fax: 520-383-4352

REFERRAL FORM

YOUTH INFORMATION			
Youth's Full Name:	Age:	DOB:	Sex:
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:		
Village (Residence):	District (Registered):		
School: <input type="checkbox"/> Indian Oasis Elementary School <input type="checkbox"/> Baboquivari Middle School	Grade:	Teacher:	
School Address:	Counselor:		
School Phone:			

INFORMATION OF REFERRING PERSON AND AGENCY			
Contact Person:	Title:	Date:	
Relationship to the Person being referred:			
<input type="checkbox"/> Parent/Legal Guardian	<input type="checkbox"/> Teacher	<input type="checkbox"/> School Resource Officer	
<input type="checkbox"/> Counselor/Social Worker	<input type="checkbox"/> School Principal	<input type="checkbox"/> Probation/Diversion Officer	
<input type="checkbox"/> Child Welfare/CPS Caseworker	<input type="checkbox"/> CHR	<input type="checkbox"/> Nurse/Doctor	
<input type="checkbox"/> Other: _____			
Referring Agency:			
Address:	City:	State:	Zip:
Phone Number:	Alternate Contact/Email Information:		
IEP <input type="checkbox"/> YES <input type="checkbox"/> NO CPS REFERRAL <input type="checkbox"/> YES <input type="checkbox"/> NO		ACTIVE CPS CASE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW	
Was Parent/Legal Guardian informed of the referral?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Parent/Legal Guardian		Relationship	
		Telephone/Contact Number	

Reason for Referral: (please check all that apply)

<input type="checkbox"/> Anger Issues	<input type="checkbox"/> Drug/Alcohol Issues	<input type="checkbox"/> History of Abuse	<input type="checkbox"/> Peer Problems	<input type="checkbox"/> Self-Esteem	<input type="checkbox"/> Truancy (attendance problems)
<input type="checkbox"/> Arrest/Legal Issues	<input type="checkbox"/> Eating Issues	<input type="checkbox"/> Homeless	<input type="checkbox"/> Poor Decision Making	<input type="checkbox"/> Sibling In Gangs	<input type="checkbox"/> Witness Domestic Violence
<input type="checkbox"/> Authority Issues	<input type="checkbox"/> Family in Transition	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> PTSD	<input type="checkbox"/> Sibling Rivalry Conflict	<input type="checkbox"/> Other:
<input type="checkbox"/> Chaotic Home	<input type="checkbox"/> Gang Related	<input type="checkbox"/> Isolation	<input type="checkbox"/> Runaway	<input type="checkbox"/> Socialization Issues	<input type="checkbox"/> Other:
<input type="checkbox"/> Depressed/Sad	<input type="checkbox"/> Grief/Loss	<input type="checkbox"/> No Male/Female Role Model	<input type="checkbox"/> School/Academic Problems	<input type="checkbox"/> Stealing	<input type="checkbox"/> Other:

Additional reasons or comments:

1. Why do you feel this youth might benefit from a Mentor?

2. What particular interests, either in school or out, do you know of that the child has?

3. What **strategies or approaches** might be effective for a Mentor working with this Youth?

4. What are the child's **strengths**? What is she/he good at?

5. **Presenting Problem.** Describe the problems(s) which prompted the Youth's referral to the Tohono O'odham Nation Youth Mentor Program. When did the problems begin? **Triggering** events? Changes in Youth since problem began?

6. Is there anything else we should know in order to help this Youth?



*Program Manager: **Lacrisha Tacheene***

SEND REFERRALS ATTENTION TO:
TOHONO O'ODHAM NATION YOUTH MENTOR PROGRAM
PO BOX 189 ♦ SELLS, ARIZONA ♦ 85634
FAX: 520.383.4352