REFERRAL FORM

Type of Class Requested: Arson Offense ________ Fire Setting ______ Other ___________________________

Referring Person: __________________________________ Agency: ___________________________________

Title:

( ) Caseworker ( ) Hearing Officer ( ) Probation Officer ( ) Police Officer ( ) Other____________

Address:

Street:___________________________ City:__________________ Zip Code:________ County:____________

Date of Referral: _____________________ Phone _____________________ Fax _________________________

Probation Expiration: ____

Child Referred:
____DOB_____________________________

ONE ADULT PARTICIPANT MUST ATTEND WITH THE CHILD FOR THE ENTIRE PROGRAM. THIS MUST BE THE CUSTODIAL PARENT OR LEGAL GUARDIAN.

Custodial Parent(s) Name:

M____ F____

Address(es):

M ____ F____

____ ____

Child living with: ____

Telephone Number(s): M: H_________________________________F: H______________________________

W_________________________________ W______________________________

Referring Offense(s):
____

Background Information (Please include any pertinent medical conditions):_____________________________

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To schedule an appointment call:
Straight Talk Program Coordinator
Beckie Hoppe RN, BSN
Hurley Trauma Center
One Hurley Plaza
Flint, MI 48503-5993
PH: 810-257-9627 Pager 810-972-0768

For office use only:

Date: ________________________________

Contacted: ___________________________

Date of Scheduled Program:___________