



REFERRAL FORM
FAX REFERRALS TO: (734) 232-3833
Please note new number



Date of referral: _____

Date probation expires: _____

REFERRING AGENCY CONTACT INFORMATION:

Title of referring person: Caseworker Fire Department Hearing officer Hospital
 Parent self-referral Police Department Probation office Other: _____

Name of referring person: _____ **Agency:** _____

Street: _____ **City:** _____ **Zip code:** _____

County: _____ **Phone:** _____ **Fax:** _____

E-mail address: _____

CHILD REFERRED

Name of child: _____ **Gender:** Female Male **DOB:** _____ **Age:** _____

Child lives with: Mother Father Legal guardian Other: _____

Referring offense: Arson Bomb threat Fire setting Fire play Fireworks Other: _____

Has set previous fires: Yes No

Offense description: _____

Background information (please include any pertinent medical conditions): None ADD/ADHD Abuse
 Anger/Violence Aspergers/Autism Asthma Depression Diabetes Learning disability
 Other: _____

CUSTODIAL PARENT(S): List the address where the child is currently living.

One custodial parent or legal guardian must attend with the child for the entire program.

Mother: _____ **Father:** _____

Street: _____ **City:** _____ **Zip code:** _____

Home phone: _____ **Work phone:** _____

E-mail address: _____

Previous/ Current contact with Child Protective Services (CPS) Yes No

For office use only

Date(s) contacted: _____ Attended Did not attend

Date scheduled: _____ Rescheduled Date: _____

Date scheduled: _____ Rescheduled date: _____