3D REFERRAL

1522 Main Street
Niagara Falls, NY 14305
Phone: (716) 255-3564
Fax: (716) 285-6984

Date of Referral: Click here to enter a date.

CLIENT INFORMATION:

Client Name: DOB: Age:

Case Date:

Last Street Address: City: Zip:

Home Phone: Cell Phone:

GENDER: _____

RACE: White ☐, Black ☐, Hispanic ☐, Asian ☐, Native American ☐, Other ☐

Pregnant: Yes ☐ No ☐ N/A ☐

Education Status: High School ☐ College ☐ Trade/Vocational ☐ Other ☐

Does NCDSS Have Guardianship / Custody? Yes ☐ No ☐

Other _____

Guardian/Custodian Name:

Street Address: City: Zip:

Home Phone: Cell Phone:

Other Family Members Living in Home

Name: Age: Relationship to Youth:

Name: Age: Relationship to Youth:

Name: Age: Relationship to Youth:

Name: Age: Relationship to Youth:

PERSON REFERRING INFORMATION:

Referral Name: _____ Phone: _____

Referral Agency: _____ Phone: _____

REASON FOR REFERRAL:

1)
2)
3)
4)

Identify Family Engagement/Prevention Goals Youth Needs Help Achieving:

1)
2)
3)
4)

Identify Youth's/Family's Strengths:

1)
2)
3)
4)

Safety Concerns:

SIGNATURE:

Referral Signature: _____

Send referrals to:
Tcarter@pinnanclecs.org
or fax to 716-995-2892
ATTN: Ta-Shara Carter
Or call: 255-3564
Coordinator of Youth Services

Date Received: _____

Assigned to: _____

Case to Open: ___YES ___ NO