Family Options Counseling, LLC

Alternatives to Sexual Assault Program – for Persons with Limited or Underdeveloped Skills (ASAP-PLUS)

Referral Form

Please complete form entirely. Please do not refer reader to other documents.

Referral Person and number: ______________________________

Client: ______________________________

D.O.B.: ______________________________

Current address *(include zip)*: ______________________________

Phone number: ______________________________

Caretaker's name: ______________________________

Guardian's name(s): _____ ______________________________

Guardian's Email Address:

Guardian's number: ______________________________

Guardian's address: ______________________________

Worker's Email Address:

Worker's phone number: ______________________________

Worker's address: ______________________________

Probation Officer: ______________________________

P.O. Phone Number: ______________________________

P.O. Address: ______________________________

Asst. District Attorney: ______________________________

Type of payment: ______________________________

Probation expiration date: ______________________________

Adults involved in parent sessions: ______________________________

Note: The referring person must be responsible for transporting or arranging reliable transportation for the youth to attend the sessions. Please contact Dr. Kimberly Young to set up an initial interview for a youth. You may send this referral form to Dr. Young.

Contact information:
Email: kyoung@FamilyOptions.com
Phone: 414-431-4444
Fax: 414-431-0858

Description of Previous Treatment: ____

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Previous Diagnoses: ____

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	Yes	No
Previous Sex Offender Treatment:	☐	☐

If yes, explain: ____

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	Yes	No
Other Delinquent Behaviors:	☐	☐

If yes, explain: ____

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Brief History of Inappropriate Sexual Behaviors *(Include specific charges)*: ____________

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Brief Family, Social, Emotional, and Academic History: ____________________________

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Additional Information: ____

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