



CAT Referral Form

Youth Information

Name: _____ Age: _____
 Address: _____ Gender: _____
 Address: _____ Race: _____

Parent/Guardian Information

Parent or Guardian Name: _____ Phone: _____

Check All That Apply:

- This youth has a documented mental health diagnosis:**
 - Unsure Diagnoses: _____
 - This youth has had at least one of the following:**
 - Repeated "traditional" treatment failures **or** in treatment with no progress/worsening
 - Recent history of crisis stabilization unit **or** psychiatric hospital admissions
 - Alternative school placement **or** at risk of "dropping out"
 - Returning home from a residential treatment facility
 - In foster care, but working toward reunification **or** adoption **or** at risk of going into foster care/shelter care
 - At risk of being placed in a Department of Juvenile Justice residential commitment program
 - Other: _____
 - This youth has family that is willing to work with the CAT Team.** **Collateral included?**
 - This youth has other providers currently working with the family.** Yes No
- Whom? _____

Referrer Information

Name: _____ Phone: _____
 Address: _____ Fax: _____
 Relationship to youth: _____ Email: _____

Forward Completed Referrals To:

Community Action Team Phone: 850-523-3333 ext. 4105
 2634 Capital Circle NE Building B Email: ChristopherC@Apalacheecenter.org
 Tallahassee, Florida 32308 Fax: 850-523-3401

*** Referrals will be contacted by CAT Team Leader within 72 hours of processing ***