



## On Point Program – Referral Form Street Level Violence Prevention and Intervention programs

## Program being referred: **Prevention Program Referral Intensive Intervention** ☐ Youturn Youth Support Services ☐ John Howard Society of Ottawa T:(613) 789-0123 F: (613) 789-1350 T: (613) 769-3638 F: (613) 828-2683 Date of Referral: □ Ottawa ☐ Russell County □ Rockland Region: Referral Source Information Self-referral (if checked skip to next section) $\square$ Referring person: Name (last, first): Telephone Number: Referring agency (if applicable): Relationship to youth: Youth Information Youth's Name (last, first): Youth's Address: Resides with: Youth's Telephone Number: Youth's Date of Birth: month day year Youth's Gender: ☐ Male ☐ Female Youth's First Language: Youth's School: Grade: School Program(s): Parent/Guardian Information Mother's Name (last/ first): Mother's Address:

Work:

Mother's Telephone Number:

| Father's Name (last, first): Father's Address: Father's Telephone Number:  | W | ork:                   |     |  |  |  |
|--|---|------------------------|-----|--|--|--|
| Guardian's Name (last, first): Guardian's Address: Guardian's Telephone Number:  |   | Work:                  |     |  |  |  |
| YOUTH INFORMATION  |   |                        |     |  |  |  |
| Why is this youth at risk of involvement in street-level violence activity?  |   |                        |     |  |  |  |
| Are there any safety issues that we should be aware of?  |   |                        |     |  |  |  |
| Are any members of the youth's family involved in street level violence?   |   |                        |     |  |  |  |
| Does the youth have friends or acquaintances that are involved in street-level violence?   |   |                        |     |  |  |  |
| Other agencies/services currently involved with the youth:  Agency: Contact Name: Tel: Agency: Contact Name: Tel: Agency: Contact Name: Tel:  Has youth agreed to the referral? Yes □ No □  Youth's reaction to referral: Positive: □Tentative: □ Negative: □  Has family agreed to the referral? Yes □ No □  Family reaction to referral: Positive: □Tentative: □ Negative: □  Is this Youth a Parent or actively parenting? Yes □ No □ |   |                        |     |  |  |  |
| Reintegration  |   | Peer Relations         |     |  |  |  |
| Substance Abuse  |   | Antisocial Attitudes   |     |  |  |  |
| Family Counselling   |   | Accommodations         |     |  |  |  |
| Managing Emotions (ie Anger)   |   | Problem Solving        |     |  |  |  |
| Employment   |   | Healthy Relationships  |     |  |  |  |
| Education  |   | Alternative to Custody |     |  |  |  |
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| Recreation                    | Mental Health Challenges |      |
|-------------------------------|--------------------------|------|
| Prevention: Group Programming | Other (specify):         |      |
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| Additional comments:          |                          |      |
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