* **MUST BE FILLED OUT AS COMPLETELY AS POSSIBLE**

Revised 8/18/22

NORTH COUNTY S.A.F.E. MEETING REFERRAL FORM

S.A.F.E. Office Use Only
Reviewed by:_____
Case Manager:_____

Region North County S.A.F.E. PH: 805-503-9638 Fax:805-462-8901 Email: cdelreal@linkslo.org

Referral Date_____ Referred By_____

Referring Agency _____Referral Phone_____

Email Address_____

REQUESTED ATTENDANCE:

Name/Affiliation **(Besides SAFE Team members)**	Phone	Email Address	Contacted
School Contact:_____			

Office use only: Pre-Staffing Meeting Start Time Location

Scheduled SAFE date/time _____ date/time _____ _____

☐ Transportation Needed ☐ Translation needed Case previously presented: ☐No ☐ Yes Date _____

CHILD'S NAME	AGE	ADDRESS	CITY	ZIP		
PHONE NUMBER	GRADE	DOB	SCHOOL OF ATTENDANCE	Current Placement	Sex	Ethnicity*
MOTHER'S NAME	DOB	PHONE	Ethnicity*	Legal Guardian's Name (If different)		PHONE
Mothers Address (if different, include city/zip)				Relationship to child		
FATHER'S NAME	DOB	PHONE	Ethnicity*	Address (if different, include city/zip)		
Father's Address (if different, include city/zip)						

SIBLING	Living in Same home	Yes/No	DOB	Sex	Ethnicity*	GRADE	SCHOOL	Others Living in the Home	DOB
SIBLING	Living in Same home	Yes/No	DOB	Sex	Ethnicity*	GRADE	SCHOOL		
SIBLING	Living in Same home	Yes/No	DOB	Sex	Ethnicity*	GRADE	SCHOOL		
SIBLING	Living in Same home	Yes/No	DOB	Sex	Ethnicity*	GRADE	SCHOOL		

CURRENT STATUS/OPEN CASES

Closed	Open	Staff	Case#
☐ DSS	☐	_____	_____
☐ CWS	☐	_____	_____
☐ Probation	☐	_____	_____
☐ Mental Health		_____	_____
☐ Public Health	☐	_____	_____
☐ Spec. Ed.	☐	_____	_____
☐ D & A	☐	_____	_____
☐ Other	☐	_____	

Previous Placement (date)_____

FINANCIAL STATUS

☐ Medi-Cal ☐ CalWORKs (families)
☐ Insurance (private) ☐ AFDC-FC (foster child)
☐ Healthy Families ☐ Other_____

*ETHNICITY CODES

10 Native American	50 Hispanic
20 Asian	60 African American
30 Pacific Islander	70 White
40 Filipino	90 Other_____

Medical Concerns/Medication(s) (Note MD's name)_____

Current Therapist/Psychiatrist _____ _____
Name Phone Number

Student/Child/Family Strengths:

Presenting concerns/specific reasons for referral. Information on siblings is extremely helpful.

1. Presenting concerns/specific reasons for referral:

☐ Substance Use	☐ Employment Concerns
☐ Parent Child Conflict	☐ Child Behavioral Concerns
☐ Loss/Grief	☐ Educational Concerns
☐ Homelessness	☐ Criminal Behavior by parent
☐ Domestic Violence	☐ Criminal Behavior by youth
☐ Financial Stress	☐ Child Developmental Concerns
☐ Child Abuse/Neglect	☐ Bonding/Attachment Concerns
☐ Medical Concerns	☐ Other_____
☐ Mental Health Concerns	

2A. What would the referring party like to see happen at the meeting/purpose?

2B. What would the family like to see happen at the meeting?

3. How are attendance, siblings, behavior, etc.?

4. What current services/agencies is the family already connected to?

5. Does the family need immediate assistance from a family advocate? Are they Spanish speaking?