

SIRP Referral Form

Each class is held monthly, over the course of 2 or 3 days (depends on the month), for a total of 12 hours in locations in the Falmouth/Yarmouth/Freeport/Pownal region.

Go to sirp.adcareme.org to register for upcoming classes, or contact Heidi Tucker,

SIRP Coordinator for Casco Bay CAN at: E-mail: cascobaycansirp@gmail.com, Phone: 207-522-1414

Youth's Name: _____ **Youth's Home Address:** _____

Youth's Phone # : _____ **Youth's Email** _____

By signing here, the Youth Participant indicates that they are aware of this Referral, have been informed about the date/time/location of the class that they are being referred to, and agree to participate: _____

Date/time/location of class: _____

Name of Parent/Guardian: _____ **Phone #:** _____ **Email:** _____

Emergency Contact Name & Phone Number (other than Parent/Guardian listed above):

Other comments or Notes from Referral Source (special conditions, special accommodations/needs, etc.):

If referral is from person other than parent, has parent been notified? _____ If so, Date of notification: _____

If not, please comment:

Date Referral Made: ____ / ____ / _____

Youth's Information

Age: ____ **Birthdate:** ____ / ____ / _____

Gender: ____ Male ____ Female

Race/Ethnicity: ____ White ____ Hispanic ____ African America ____ More than one
 ____ Asian ____ American Indian ____ Alaska Native
 ____ Native Hawaiian ____ Pacific Islander ____ Other

Name of Youth's School, Grade and Town: _____

Referral Initiated By _____

(list name, title and relationship to youth). This is who will be notified prior to the SIRP class and when the youth has successfully completed the SIRP program. By signing below, the Youth confirms that they are giving permission to notify the Referral contact identified above concerning Program Status. **Youth Signature:** _____

Referent's Phone # _____ **Fax #** _____ **Email:** _____

Person Completing Referral Form: _____

(list name, title and relationship to youth and/or to the Referral Source)

Reason for Referral <i>(check all that apply)</i>	Month and Year of the Most Recent Violation/Incident Leading to Referral <i>(mm/yyyy)</i>
____ Self Referral to Program	Not applicable
____ Parent/Guardian Referral	Not applicable
____ Violation of School Drug/Alcohol Policy	Date: ____ / ____ ____ (if available)
____ Arrest or Citation involving drugs and/or alcohol	Date: ____ / ____ ____ (if available)
____ Violation of Probation	Date: ____ / ____ ____ (if available)
____ Reports (by self or other) of being impaired within last 30 days	Date: ____ / ____ ____ (if available)
____ Other (please explain):	Date: ____ / ____ ____ (if relevant)