Riverside Community Care

Leading the Way in Behavioral Healthcare & Human Services

NEWTON YOUTH OUTREACH PROGRAM

64 Eldredge Street, Newton, MA 02458
Tel: 781-443-9419 Fax: 617-244-2507

Please complete this form in full, attach the student's schedule, and email to NYO@riversidecc.org

Today's date:

Student's name:

Gender identity & pronouns:

Date of birth: **School:** **Grade:**

Guidance counselor: **Guidance counselor phone:**

Person submitting referral (if not guidance counselor listed above):

Phone number of person submitting referral (if not guidance counselor):

Name of parent(s)/guardian(s):

Home address:

Phone: **Email:**

Insurance (if known):

Is the child willing and able to sit and engage in a therapeutic session on a weekly basis for at least 30 minutes? Yes ☐ No ☐

- Does this student have an IEP? Yes ☐ No ☐ If yes, please elaborate on student's needs:

- Is this student in any specialized program? Yes ☐ No ☐ (If so, please list):

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- Does this student have any known medical conditions? Yes ☐ No ☐ (If so, please list):

- We request that parent(s)/guardian(s) be verbally notified prior to submission of the referral. Has this parent/guardian been notified? Yes ☐ No ☐
- We request that all clients enroll in counseling voluntarily. Have you confirmed that this student will attend voluntarily? Yes ☐ No ☐
- We thank you for your partnership and, as visitors to your building, we rely on you to arrange a confidential weekly meeting space. Do you agree to secure space for these sessions? Yes ☐ No ☐
- Are any other support services already in place (e.g., therapist)? Yes ☐ No ☐

Reason for referral:

Other comments:

Please **attach the student's schedule** to this form and **circle the times** when they are best able to be seen for counseling. We cannot process the referral in a timely manner without the student's schedule.