

Oakview Juvenile Residential Center
67701 Oakview Road
St. Clairsville, Ohio 43950
(740) 695-3500



REFERRAL HISTORY

LAST NAME: _____ FIRST NAME: _____ MI: _____

DOB: _____ SSN: _____ AKA: _____

PHYSICAL MARKS: _____

SEX: _____ HT: _____ WT: _____ HAIR: _____

EYES: _____ RACE: _____ CORRECTIVE LENSES: _____

PARENT/GUARDIAN: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME TELEPHONE: _____ WORK TELEPHONE: _____

COMMITTING COURT: _____ COMMITTING JUDGE: _____

CURRENT CASE# _____ ORC # _____ OFFENSE LEVEL: _____

DOES YOUTH ADMIT TO DRUG AND ALCOHOL USE AT TIME OF OFFENSE: ____ YES ____ NO

DID YOUTH USE A WEAPON: ____ YES ____ NO TYPE OF WEAPON: _____

PROPERTY DAMAGE ____ YES ____ NO

AGE OF VICTIM IF OFFENSE AGAINST PERSON: _____

VICTIMS RELATIONSHIP TO OFFENDER: _____

WAS VICTIM PHYSICALLY INJURED: ____ YES ____ NO

YOUTH'S NAME: _____

AGE OF FIRST ADJUDICATION: _____ YEARS _____ MONTHS

NUMBER OF PRIOR ADJUDICATIONS(EXCLUDING COMMITTING AND CURRENT OFFENSES):

F1 _____ F2 _____ F3 _____ F4 _____ F5 _____ MISD _____ UNRUL _____

PROB VIOL _____

MOST SERIOUS PRIOR DISPOSITION:

_____ DYS COMMITMENT	_____ NON-SECURE PLACEMENT
_____ SECURE PLACEMENT	_____ SUSPENDED COMMITMENT
_____ PRIOR COMMITMENT	_____ OTHER, SPECIFY _____
_____ PROBATION	_____ NOT APPLICABLE

PRIOR DYS NUMBER: _____

WAS YOUTH ENROLLED IN SCHOOL AT THE TIME OF OFFENSE: _____ YES _____ NO

LAST SCHOOL ATTENDED: _____

CURRENT GRADE: _____ EMPLOYED: _____ YES _____ NO

TYPE OF EDUCATION: _____ MAINSTREAM _____ VOCATIONAL _____ GRADUATED
 _____ SPECIAL ED _____ SUSPENDED _____ EXPELLED
 _____ HOME INSTRUCT _____ GED _____ DROP OUT
 _____ CHAPTER ONE

DOES YOUTH HAVE A CURRENT INDIVIDUALIZED EDUCATIONAL PLAN (I.E.P.): _____ YES _____ NO

SUBSTANCE USE: _____ YES _____ NO SUBSTANCE ABUSE: _____ YES _____ NO

TYPE OF SUBSTANCE: _____ DRUG _____ ALCOHOL _____ BOTH

PRIOR SUBSTANCE ABUSE TREATMENT: _____ NONE
 _____ RESIDENTIAL
 _____ OUTPATIENT

NAME OF TREATMENT CENTER IF APPLICABLE: _____

HAS YOUTH EVER TRIED TO COMMIT SUICIDE: _____ YES _____ NO

DOES YOUTH HAVE A HISTORY OF SELF MUTILATING BEHAVIOR: _____ YES _____ NO

DOES YOUTH HAVE A HISTORY OF FIRE SETTING: _____ YES _____ NO

HAS YOUTH EVER BEEN IN COUNSELING _____ YES _____ NO IF YES, WHERE _____

YOUTH'S NAME: _____

FAMILY PHYSICIAN: _____

ADDRESS: _____ PHONE: _____

DOES YOUTH HAVE ANY ALLERGIES TO MEDICATION: _____ YES _____ NO EXPLAIN: _____

DOES YOUTH HAVE ANY ALLERGIES TO FOOD, INSECT BITES, ANIMALS, OR ENVIRONMENTAL ALLERGIES: _____ YES _____ NO EXPLAIN: _____

IS YOUTH CURRENTLY TAKING ANY MEDICATION: _____ YES _____ NO IF YES, LIST TYPE, DOSAGE, AND START DATE: _____

HAS YOUTH EVER BEEN SEXUALLY ABUSED: _____ YES _____ NO
IF SO, BY
WHOM _____

SIGNATURE OF INTERVIEWEE DATE

SIGNATURE OF INTERVIEWER DATE

****PLEASE ATTACH COPY OF CRIMINAL PRIORS AND ANY OTHER PERTINENT INFORMATION.

****IF ACCEPTED INTO THE PROGRAM, COPIES OF THE FOLLOWING ARE NEEDED: BIRTH CERTIFICATE, SOCIAL SECURITY CARD, IMMUNIZATION RECORD, SCHOOL RECORDS, INSURANCE/MEDICAL CARD, AND COMMITTING JOURNAL.