REFERRAL FORM

Send to: kahrns@med.umich.edu
Or fax to: 734-232-3833

Straight Talk

University of Michigan Trauma Burn Center

Date of referral: _____ Date probation expires: _____

REFERRING AGENCY CONTACT INFORMATION:

Title of referring person: ☐ Caseworker ☐ Fire Department ☐ Hearing officer ☐ Hospital

☐ Parent self-referral ☐ Police Department ☐ Probation office ☐ Other: _____

Name of referring person: _____ **Agency:** _____

Street: _____ **City:** _____ **Zip code:** _____

County: _____ **Phone:** _____ **Fax:** _____

E-mail address: _____

CHILD REFERRED

Name of child:_____**Gender:** ☐Female ☐Male **DOB:** _____ **Age:** _____

Child lives with: ☐Mother ☐Father ☐Legal guardian ☐Other: _____

Referring offense: ☐Arson ☐Bomb threat ☐Fire setting ☐Fire play ☐Fireworks ☐Other: _____

Has set previous fires: ☐Yes ☐No

Offense description: _____

_____

_____

Background information (please include any pertinent medical conditions): ☐None ☐ADD/ADHD ☐Abuse ☐Anger/Violence ☐Aspergers/Autism ☐Asthma ☐Depression ☐Diabetes ☐Learning disability ☐Other: _____

_____

CUSTODIAL PARENT(S): List the address where the child is currently living.

One custodial parent or legal guardian must attend with the child for the entire program.

Mother: _____ **Father:** _____

Street: _____ **City:**_____ **Zip code:** _____

Home phone: _____ **Work phone:** _____

E-mail address: _____

Previous/ Current contact with Child Protective Services (CPS) Yes ☐ **No** ☐

For office use only

Date(s) contacted:_____ ☐ Attended ☐ Did not attend

Date scheduled: _____ Rescheduled Date erkqweroqwpoiqrwe

Date scheduled: rewpoweirtporiow Rescheduled date: reqopriqpeiqpoieq