

REFERRAL FORM

Seaside Youth Resource Center

1136 Wheeler Street, Seaside, CA 93955
831-899-6870 | 831-899-6871 | 831-899-6868

SYRC Office Staff

Date Received: _____
Date Contacted: _____
Date of Intake Appt.: _____
Date Closed: _____

Seaside Youth Resource Center | Office Hours: Monday-Friday, 9 AM – 6 PM

Please email to ecuadra@ci.seaside.ca.us and tblack@ci.seaside.ca.us
and dgarrett@ci.seaside.ca.us or drop off at SYRC

Instructions: Please fill in the following information if you would like to refer a client to the Seaside Youth Resource Center (SYRC). You and/or the client/guardian will be contacted by a Staff Member from the SYRC about the next steps to schedule an appointment to begin services that meet the needs of the youth, family, and/or young adult. The SYRC is a one-stop referral-based program providing our youth and their family's access to a variety of service providers operating as local agencies, non-profit organizations, faith-based group, etc. to support the dynamics of their children/family needs and/or challenges and other opportunities for them to thrive and be successful.

Referred By

Date: _____ Referred by: _____ How did you hear about SYRC?
Telephone #: _____ Agency: _____ School Friend Flyer/Brochure
Title: _____ Email: _____ SYRC Client SYRC Staff
Is the client/family aware they are being referred? Yes No Behavioral Health Probation Dept.
Notes: _____ Other: _____

Client Referred

Child's Full Name: _____ Gender: _____ DOB: _____ Age: _____
Primary Language: _____ School: _____ Grade: _____
Address: _____
Currently on probation? Yes No P.O. Name: _____
Ethnicity (please check all that apply): African-American Asian Caucasian Indian Latino
 Native-American Pacific Islander Other: _____
Is this client receiving services from any other county/city agency/programs? Yes No
If yes, please list: _____

Client's Guardian

Primary Guardian Name: _____
Primary Language: _____
Relation to Client: _____
Phone Number: _____
Alt. phone number: _____

Additional Notes, Strengths, Interests:

Reasons for Referral

Behavior issues at school Failing Grades Truancy
 Gang activity Gang Involved Family gang-involved Notes: _____
 Experimenting with drug/alcohol Substance abuse Substances: _____
 Violent towards others Aggressive behaviors/attitude Explain: _____
 Suicidal Suicidal ideation History of suicide attempts Last attempt: _____ Hospitalized? _____
 Drug/Alcohol counseling Therapy (individual/family) Mentoring/positive guidance support
 Employment experience/opportunity Youth leadership/development program
 Other: _____