REFERRAL FORM
Seaside Youth Resource Center

1136 Wheeler Street, Seaside, CA 93933
831-899-6871

SYRC Office Staff:
Date received: _____
Date contacted: _____
Date of intake apt: _____
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 khiggins@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 an/or challenges and other opportunities for them to thrive and be successful.

Referred By

Date: _____ Referred by: _____
Telephone #: _____ Agency: _____
Title: _____ Email: _____
Is the client/family aware they are being referred? ☐Yes ☐No
Notes: _____

How did you hear about SYRC?
☐School ☐Friend ☐Flyer/Brochure
☐SYRC Client ☐SYRC Staff
☐Behavioral Health ☐Probation Dept.
☐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, or Interests...
_____
_____
_____
_____

Reasons for Referral

☐Behavior issues at school
☐Gang activity ☐Gang-involved
☐Experimenting with drug/alcohol
☐Violent towards others
☐Suicidal ☐Suicidal ideation
☐Drug/alcohol counseling
☐Employment experience/opportunity

☐Failing Grades
☐Family gang-involved
☐Substance abuse
☐Aggressive behaviors/attitude
☐History of suicide attempts
☐Therapy (individual/family)
☐Youth leadership/development program

☐Truancy
Notes: _____
Substances: _____
Explain: _____
Last attempt: _____ *Hospitalized?* ___
☐Mentoring/positive guidance support

☐Other: _____