



Referral to Bacon Street Youth and Family Services

Name: _____ DOB: _____ Gender: _____

School: _____ Grade: _____ Race/Ethnicity: _____

Parent/Guardian Name: _____

Address: _____ Telephone (home): _____

_____ Telephone (cell): _____

Is this person homeless or struggling with housing stability? (Circle One) Yes No

Preferred Service Location:

____ Williamsburg ____ Gloucester

____ Yorktown ____ Hampton/Newport News

Reason for Referral (attach additional pages if needed):

Which services are the client interested in receiving? (Check all that apply):

____ Individual Substance Use/Abuse Counseling ____ Family Counseling

____ Individual Outpatient Mental Health Counseling ____ Group Counseling

____ Case Management/Referral Services ____ Drop-in Center (Hampton only)

Does this person have insurance? (Circle One) Yes No

Insurance Co: _____ Insured Name: _____ ID #: _____

Referred By: _____ Contact #: _____

Please fax or scan this referral form along with the attached consent form to:

Bacon Street Youth and Family Services
Phone: 757-253-0111 Fax: 757-253-2884

referral@baconstreet.org



CONSENT TO EXCHANGE CONFIDENTIAL RECORDS

Child/Youth under 18 years of Age

I, the parent or guardian of _____ do hereby consent to the exchange of confidential information regarding my son/daughter between _____ (referring agency) and Bacon Street Youth and Family Services. I understand that this material is confidential and will be used only by professionals working with my child.

Date

Parent/ Guardian signature

Adult Ages 18+

I, _____ do hereby consent to the exchange of confidential information regarding my case between _____ (referring agency) and Bacon Street Youth and Family Services. I understand that this material is confidential and will be used only by professionals working with me.

Date

Signature