

Next Court Date:	Time:
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Adolescents with Problematic Sexual Behavior (PSB-A) Referral Form

Name:		Date of Incident:
Date of Birth:	Age:	Date of Referral:
SSN:	Current Legal Custody:	Ethnicity:
Gender:		
Current Residence:		
Parent/Guardian:	Name:	
	Address:	
	Phone: (work)	(home)
	(other)	

Method of Payment:	<input type="checkbox"/> OJA	<input type="checkbox"/> JB	<input type="checkbox"/> Other	
Charge:				
Person Making Referral:				
Relation to Patient:			Phone:	
Reason for Referral:				

D.A.	Phone:
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Attorney:	Phone:
Address:	
<input type="checkbox"/> Public	<input type="checkbox"/> Private

DHS Case Worker:	Phone:	Fax:
Address:		

Probation Officer:	Phone:	Fax:
Address:		
Email Address:		

Current Adjudication	<input type="checkbox"/> YO	<input type="checkbox"/> Delinquent	<input type="checkbox"/> Deferred	<input type="checkbox"/> IA	<input type="checkbox"/> Other
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	Requested	Sent	Received	Reviewed by:	BB	SM	PS
Background Information							
Police Record							
Psychological Evaluation							
Current Treatment Information							

Interviewed by:	Date/Time:
Case Staffed:	Date/Time:
Disposition/Recommendations:	
Follow-up Letter Sent To:	