



**RESTORATIVE JUSTICE WINONA COUNTY
REFERRAL FORM
FAX # (612) 473-5452**

DATE: _____

REFERRAL SOURCE:

Name: _____

Agency: _____

Phone: _____

REASON/TYPE OF REFERRAL:

- Circle
- Community Group Conference
- Mentoring
- Victim Empathy Class

Briefly explain reason for making referral: _____

JUVENILE/CLIENT INFORMATION:

Name: _____

DOB/Age: _____

Address: _____

Name of Parent(s): _____

Phone: _____

Phone: _____

MENTAL HEALTH CONCERNS: _____

ACADEMIC PROFILE:

School attending: _____

Grade: _____

Attendance: _____

Attitude towards school: _____

PLACEMENT HISTORY:

Has the juvenile ever been/or is currently placed outside the home? _____

Current Placement: _____

Date of Release: _____

List Past Placements and approximate length of stay: _____

CHEMICAL DEPENDENCY ISSUES:

Does the juvenile abuse alcohol/drugs? _____

Has the juvenile received any CD Treatment? _____

If yes, where _____

and how long? _____

Other Key Relationships Working with the Juvenile: Family, Friends, Counselors, Teachers, Probation Officer, Social Worker, Principal, Community Members . . .

Name	Title	Contact Number / Email
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe the strengths of the juvenile: _____

Describe the weaknesses of the juvenile: _____

