Surry County Office on Youth

P. O. Box 65 203 Church Street
Surry, VA 23883
PH: 757-294-5278 Fax: 757-294-3079
shpierce@surrycountyva.gov

_____ _____

Date of Referral Date Referral Received to SCOOY

Full Name of Individual Being Referred: _____Gender:_____DOB:_____

Name of Parent/Guardian: _____

Complete Address:_____City_____ State_____ Zip_____

Home Telephone #_____ Cell Telephone:_____

Reason for Referral: _____

_____

Type(s) of services currently provided: _____

_____

Other agency's currently serving youth:_____

_____

Type(s) of Services Needed: (Check all that apply)

____Career/College Guidance	**____Caring Adult (Mentor)**	**____Employment Services**
____Educational Support	**____Group Counseling**	**____ Individual Counseling & Guidance**
____Independent Living	**____Health Awareness**	**____Substance Abuse Prevention**
____Opportunities to Help Others	**____Parenting or Fatherhood Support**	**____Leadership/Character Education**
____Support Services	**____Work Experience**	**____Safe Place & Structured Activities**

____Other, Specify:_____

General Information

Name of Person & Agency Making Referral **Phone Number**

____ _____ **_____**

Address (Street & PO) **Fax Number /Email**

_____ **_____**

City_ _____Zip_____ **_____**

For Office Use Only

Did the individual, parent, or guardian contact the Office on Youth for services?____Yes ____No If yes, Date:_____

Follow Up Action Taken:_____Date:_____Staff Initials:_____