



REFERRAL/ENROLLMENT FORM

2753 W. Central Ave
Toledo, Ohio 43606
419-243-1119
419-243-4534 (fax)

www.positiveconnections4u.org

Referral Date: _____

Parent/Guardian's Name: _____ Who in the child's life is struggling with Mental
emotional, behavioral symptoms (give diagnosis)? Parent _____ Sibling _____ Other _____

Child's level of awareness regarding love ones illness? _____

Child's Name: _____ Diagnosis: _____ Age: _____ Gender: _____ Race: _____

Child's level of awareness of own diagnosis? _____

Address: _____
Street city zip county

Home Telephone # _____ other#: _____ transportation? _____

Is the custodian of this child different from above? _____ Child in foster care? _____

Guardian (name & #) _____ CSB worker & #: _____

Is parent/guardian aware that we will be contacting them re: this referral? _____

What is the family's level of commitment to group completion? _____

If the child is under 8, do you think they can manage and learn within a group setting? _____

Please identify attributes that we should know about to increase group participation? (Reading/learning,
behavior difficulties, learning style, likes/dislikes etc) _____

If applicable, how does the sibling group get along at home & in social settings? _____

Do you think they will do well in a group together? _____

Referring Agency: _____ Contact Name & #: _____

Please note that we contact referrals will be placed on our waiting list to be contacted accordingly & group participation is based on ability to participate. Please ensure parents are aware that you are making this referral. Thank you.

Please Fax To: Stephanie A. Souza @ 419-243-4534 Or submit via website:
www.positiveconnections4u.org

Initial Contact made: _____ Enrollment form: _____ Intro Letter _____