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**MENTORING PROGRAM
 CLIENT REFERRAL FORM**

Date: _____

Client's Name: _____

Date of Birth: _____

Grade: _____

Requested By: _____
Name of professional making referral / relationship to client

Reason for referral: _____

Describe client's strengths/weaknesses: _____

How does this child/youth compare with peers in the following areas (please check appropriate box):

	Well Below Average	Below Average	Average	Above Average	Well Above Average	Don't Know
Academic Performance						
Attitude Toward School						
Social Skills						
Attitude toward Others						
Level of Self Esteem						
Verbal Communications Skills						
Working to Potential						
Self Control						

Describe successful strategies for working with this child/youth: _____

Continued on the back...

In what specific ways do you think a BB/BS Mentor can help this child/youth? _____

Is the Parent/Guardian aware that you are making this referral? Yes No

Is the Client aware that you are making this referral? Yes No

Comments: _____

Primary Care Giver Information

Parent/Guardian's Name: _____

Relationship to Child: _____

Address: _____ City, State, Zip: _____

Phone (Home): _____ (Work): _____

Email: _____

Lives with: _____

Mother's Name: _____

Father's Name: _____

Signature of Person Making Referral: _____

Date: _____

Phone Number: _____

Email: _____