AIM Referral Form

Today's Date: _____

Referral Demographic Information:

Name of Primary Caregiver (relationship):	Telephone/ Email:
Name of Secondary Caregiver (relationship):	Telephone/ Email:
Address (including zip code):	County of Residence:
Youth/Teen Name:	Date of Birth:
Gender:	Ethnicity:
Current School:	Grade:
IEP: ☐ Yes ☐ No	504 Plan: ☐ Yes ☐ No

Referral Source Name: _____ **Relationship:** _____

Referral Number: _____ **Email:** _____

Reason for Referral:

Any Agency Involvement:

☐ WIC	☐ Hospital_____	☐ Children's 1st	☐ Other.
☐ DFCS	☐ YMCA SITE: _____	☐ Foster Care	Specify:
☐ Babies Can't Wait	☐ Sheltering Arms SITE: _____	☐ School_____	
☐ Health Department	☐ Shelter	☐ CSB/Provider	

☐ **Parent/Guardian is aware that this referral has been made and that the program director will contact them directly.**

Thank you for your referral
Send completed referral forms to: care@aimatlanta.org