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Referral Form

This form is to be completed by the referring agency or person and returned to Lakes Area Kinship. Information on this form will be kept confidential and will be used to assist Kinship in matching the child with an appropriate adult volunteer. Please take the time to fill in all information completely to the best of your knowledge.

Date: _____

Referring Agency/Employer: _____

Address: _____ City & State: _____ Zip: _____

Contact Person: _____ Title: _____

Phone Number: _____ Ext.: _____

Child's Data

Name: _____ Home Phone: _____

Child Living With: _____ Relationship to Child: _____

Street Address: _____ City: _____ Zip: _____

Mailing Address: _____ City: _____ Zip: _____

Date of Birth: _____ Ethnic Origin: _____ Gender: _____

Legal Guardian: _____

Family Child History

Is there history of any of the following?

Physical Abuse _____

Please explain:

Sexual Abuse/Incest _____

Neglect _____

Mental Health Issues _____

Chemical Dependency/Alcoholism _____

Suicidal Tendencies _____

Disability/Handicap/Illness _____

School/Education Information

School child is currently attending: _____

Grade: _____ Subjects child most enjoys: _____

Participation in school activities: _____

Other Agency Information

Do you know of any other agencies working with this child or family? Yes____ No____

If yes, please list any of which you know: _____

Recommendations for Matching

Which mentoring relationship do you think this child would most benefit from?

Family_____ Couple_____ One-to-One_____

How do you think an adult volunteer would help this child?

What type of person would you suggest we match with this child?

Is this family expecting contact from Kinship?_____

Other comments:

If you have any questions or further comments, please feel free to contact the office indicated on the front of this form. Thanks!