

MHJJ REFERRAL SCREEN

Revised 08/1/2025

If you mark a 'Yes' to any of the following, please fax or mail this form to make a referral to the MHJJ Program:

YES NO

Current/Prior involvement with the Juvenile Justice System.....

If Yes: List County(ies) _____

Any DCFS Involvement

If Yes: Caseworker Contact Info _____

Current/Prior School Suspensions or Alternative School Referrals.....

Involvement in at- risk behavior with Mental Health concerns.....

Concerns of feeling Unsafe.....

Current/History of Mental Health Diagnosis.....

Current/Previously prescribed Medication(s).....

If Yes: List Medications _____

Current symptoms of Sad or Depressed mood.....

Problems with controlling Anger.....

Current/History of Aggression

If Yes: List Examples _____

Experience with excessive Fear or Anxiety

Current/History of Substance Use.....

If Yes: List Use _____

Currently or at- risk of Homelessness.....

If Yes: List (couch surfing or not living with guardian) _____

Unable to list at least one or more family member(s) for support.....

History of Exposure to Potentially Traumatic Life Events, for example: **YES NO**

Crime Victim, Witnessed/Experienced Abuse, Severe Neglect, Domestic or Community Violence

THE PERSON MAKING THIS REFERRAL SHOULD COMPLETE ALL SECTIONS BELOW:

Referral Source Name: _____ Your Role/Title: _____

Email Address _____ Your Phone #: _____

Today's Date: _____

YOUTH's NAME: _____ Gender: M F School: _____

Date of Birth: __/__/__ Age: _____ MH Diagnosis: _____

PO: _____ PO Phone # _____

PARENT/GUARDIAN CONTACT INFORMATION:

Name: _____ Relationship: _____ Primary Language: _____

Phone: (____) _____ - _____ Address: _____ City: _____

TO FIND ADDITIONAL RESOURCES, CONSIDER THE FOLLOWING SEARCH OPTIONS:

[BEACON Public Portal](http://beacon.illinois.gov) (beacon.illinois.gov)

[Spider](http://spider.dcf.illinois.gov) (spider.dcf.illinois.gov)