



**DC Central Kitchen, Inc  
Department of Social Services  
Community Agency Referral**

**Agency:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Office Telephone:** \_\_\_\_\_

**Cell:** \_\_\_\_\_

**Fax:** \_\_\_\_\_

**Contact Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Date of referral:** \_\_\_\_\_

**Name of client referring to the Culinary Training Prog:** \_\_\_\_\_

**Reason for referral:** \_\_\_\_\_

**MH History**

**Psychiatric Agency/Facility**

**Dates**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**SA/AA Treatment Programs**

**Treatment Program**

**Dates**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## Community Agency Referral continued

### Trauma

Has the client ever suffered from trauma? \_\_\_ Yes \_\_\_ No

Please describe the trauma history. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Alcohol and Drug Use

	Drug of choice	Method of Use	Frequency of Use	Date of Last Use
Primary	_____	_____	_____	_____
Secondary	_____	_____	_____	_____
Tertiary	_____	_____	_____	_____

### Psychosocial and Environmental Problems

- |  |   |
|--|---|
| <input type="checkbox"/> A. Housing Problems           | <input type="checkbox"/> E. Problems Accessing Health Care Services           |
| <input type="checkbox"/> B. Educational Problems       | <input type="checkbox"/> F. Problems Related to Interaction with Legal System |
| <input type="checkbox"/> C. Economic Problems          | <input type="checkbox"/> G. Occupational or Vocational Problems               |
| <input type="checkbox"/> D. Domestic Violence Problems | <input type="checkbox"/> H. Family Problems                                   |

What skills would your client be bringing into the program?

Skill 1 \_\_\_\_\_

Skill 2 \_\_\_\_\_

Skill 3 \_\_\_\_\_

What goals are you currently working on with the client?

Goal 1 \_\_\_\_\_

Goal 2 \_\_\_\_\_

Goal 3 \_\_\_\_\_

**What skills would you like your client to obtain from the CJT Program?**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**What current challenges are you having with the client?**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Are you willing to maintain collateral support with DCCK and attend meetings so we can help the client be successful?**

Yes  No

**Are there any programmatic restrictions that would prohibit or interfere with the client's ability to participate in programs between 8:30 AM -4:00 PM**  Yes  No

(Please specify the restrictions and include times of day your client will not be available)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Enclosures required**

Consent of release signed by client