

ATLANTA LEGAL AID SOCIETY, INC.
TEAMCHILD ATLANTA

151 Spring Street, N.W.
Atlanta, Georgia 30303-2097
(404) 614-3955
Fax (404) 614-3997

JUVENILE REFERRAL FORM

Referral Source: _____
Name Phone Date
____ Judge ____ Probation Officer ____ Juvenile Attorney ____ Other

Client Name: _____
Phone DOB

Social Security No.: _____

LEGAL CUSTODY: Parent ____ DFCS ____ Self ____ Other _____

CUSTODIAN'S NAME(S) _____
(parent, DFCS case worker or other)

CHILD'S PERMANENT ADDRESS _____

CUSTODIAN(S) PHONE: home _____ work/other _____

NEXT COURT DATE ____/____/____ **TYPE OF HEARING** _____

IS CHILD DETAINED? ____ yes ____ no **DATE DETAINED** _____

JUDGE _____ **PO** _____

CONDITIONAL RELEASE ORDERS: _____

Comments/Suggestions: (In what direction is this youth headed? Please provide information / conjectures about what is likely to happen if Team Child services are not provided. Use the back of this sheet if needed)

____ Client has been given Team Child Atlanta number and has agreed to call Team Child Atlanta
____ Client aware of referral ____ Client's parent(s) guardian(s) aware of referral