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Phoenix Center

Prevent • Treat • Recover

Why Try Program Referral Form

Name:_____ DOB:_____

School:_____ Grade:_____

Address:_____

City:_____ State:_____ Zip:_____

Parents/Guardian:_____ Phone:_____

Referral Agency:_____

Referral Agent:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Email:_____

Reason for referral:

What other Services/Agencies are currently being used or have been used in the past and to address what issue?

Is the participant currently on medication? Yes ☐ No ☐

Medication and Dosages:

Does the participant have any educational, physical, or mental health diagnoses? Yes ☐ No ☐

If yes, please indicate what the diagnosis is:

What would you identify as the participant's/ family's strengths?

Form Completed By: _____ Date: _____

Program Agreement:

Participants must commit to attend 10 weekly group meetings and cover class fee ($150) in order to successfully complete the Why Try Program.

For Questions or additional information, please call or e-mail:
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