The Resolution Group, Inc.
Resolving Child, Adolesent and Adult Sexual Conflict
623 W. Southern Ave. Suite #7 Mesa, AZ 85210
Phone: 480-962-9288 Fax: 480-962-1293

REQUEST FOR DIRECT SUPPORT or Specialty Provider Services

Identified Provider: ___________________ **Date of Referral:** _____________

Member Information

Youth's Name ________________

Date of Birth: _________________ **Age:** _____

Member ID Number: __________________

Youth's Physical Address: _____________________________

Phone: ______________ **Youth's Primary Language:** ___________________

Male___ **Female**___

Preferred Pronouns ______________________

Guardian's Information

Guardian's Name: ___________________ **Best Time to Contact:** _______________

Guardian's Address (if different than above): ___________________________________

Guardian's Phone (if different than above): ___________________________

Guardian's Relationship to Youth: ___________ **Guardian's Primary Language:** _________

School Information

School Name: _________________________

Facilitator Name: _____________________ **Title/ School Position** ______________

Facilitator's Direct Phone: ______________________ **Fax #:** ___________________

Facilitator's Email Address: ______________________

Description of the services being requested? ____

Frequency, days, and times of Services needed: ____

Why does this youth need this service?: ____

Additional Comments:

☐ I, as a schools staff member, have discussed my concerns with the parents/guardian and verbal permission was given to make this referral

Electronically Signed by: ___________________

Facilitator's Signature and Date: __________________________________

This section to be completed by the receiving provider:

______ *Referral Accepted*

______ *Referral Declined*

If declined, please provide a reason for decline: ___________________________________