



YOUTH FIRESETTING PREVENTION & INTERVENTION PROGRAM



Client Referral Form

Date:

Referring

Agency:

Party: Address:

Email:

Office Phone:

Office Fax:

Youth Name

Nickname:

Sex: M M F

Date of Birth

Age:

Race:

County: K NC S

Street Address

City:

State: DE Zip:

Caregiver 1 Name:

Role:

Phone:

Caregiver 1 Email:

Lives w/ Youth:

Receives Texts: Y N

Caregiver 2 Name:

Role:

Phone:

Caregiver 2 Email:

Lives w/ Youth:

Receives Texts: Y N

School Name:

District:

Grade:

Individualized Education Plan: Y N

504 Plan: Y N

Mental Health Diagnosis(es):

Psychiatric Medications: Y N

Therapist Name:

Medication / Drug Name Dosage

Therapist Phone:

Office Address:

Frequency: Weekly Bi-Weekly Monthly

DPBHS Specialist: Y N

Specialist Name:

Previous Firesetting: Y N

Previous Firesetting Age(s) / Year:

Previous Firesetting -Description of Incident(s):

Was Previous Firesetting Reported/ Fire Dept Response: Y N

Recent Firesetting - Date/Month:

Incident Number:

Youth Arrested/Adjudication? Y N

Court Representative:

Recent Firesetting -Description of Incident(s):

Please note: Caregivers must be informed of the client referral and accepting of the inclusion of the youth into this program prior to referral.

Rebekah L. LePore, MS
Youth Firesetting Program Manager

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<https://statefiremarshal.delaware.gov/special-programs/juvenile-firesetter-intervention-program/>