



Legal Aid of West Virginia
Family Advocacy Support and Training Referral Form
(Fax completed referral form and authorization to (304) 345-5934)

Date of Referral: _____ Referring Organization: _____

Contact Person: _____ Phone Number: _____

Name of Child: _____ Date of Birth: _____

Current Address: _____

Name of Legal Guardian: _____ Telephone: _____

Address (if different than above): _____

The Child is experiencing or has experienced (check all that applies):

___ Anxiety and/or stress related difficulties

___ Behavioral problems

___ Attention Deficit disorders or difficulties

___ Substance abuse

___ Impulse control difficulties

___ Academic difficulties

___ Learning disorder or difficulties

___ Peer or Social difficulties

___ Depression

___ Challenges associated with
developmental disorders and/or intellectual
disability

___ Other: _____

What is/are the child's diagnosis? _____

Date of Diagnoses: _____

Please provide a brief summary of advocacy needed:

(Fax completed referral form and authorization to (304) 345-5934)
(Please call 1-866-255-4370 with any questions)

Revised 4/10/08

