YAMS
YOUTH ANGER MANAGEMENT SERVICES

Today's date: _____

Name of person submitting referral: _____

Agency/School:_____

Address: _____

(City) (Zip)

Phone: _____ Fax: _____

Name of Person being referred: _____

Address: _____

(City) (Zip)

Phone: _____

Date of birth: _____ Age: ____ Gender: _____ Race: _____

Is this voluntary? □Yes □No

Is this ordered by □ Superior Court □ Department of Social Services □Other

If other, please explain: _____

Reason for referral:

_____

_____

_____

_____

_____

Return the form to YAMS@ivlgbtcenter.com

760.592.4066

By signing, I (participant) commit to attend the program for 12 weeks (once a week, 1.5 hours):

_____ _____

Participant's Signature Date

_____ _____

Parent/Guardian's Signature Date

Rd022024