

**Edwin Fair CMHC**

**Oklahoma Systems of Care**

**Referral**

Site: \_\_\_\_ Referral Date: / /

Referring Organization:

Referring Person: Phone:

Client’s Legal Name: \_\_\_\_\_\_ Client’s Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: / / Gender:

Medicaid/Member #: Social Security #:

Race / Ethnicity: *(Check all that apply.)*

White  Black / African American  Asian  Other *(Specify)*: \_\_\_

Hispanic/Latino  American Indian: Enrolled Tribe

Address:

City: County: State: Zip Code:

Primary Phone: Secondary Phone:

For dependent children or youth:

Caregiver 1 Name: Relationship to Child:

Caregiver 2 Name: Relationship to Child:

**Involved Organization(s) and Circumstance(s) (Check all that apply.)**

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| --- |
| **Child Welfare:**  Involved (open CW case)  In DHS custody KIDS #:  Child Protective Services  Family Centered Services  Permanency Planning |
| **OJA:**  Involved  In custody OJA #: |
| **Other Law Enforcement** *(specify):* |
| **Primary Care** – If chronic health condition *(specify)*: |
| **School System:**  IEP  504 Plan  Other *(specify)* |
| **Inpatient Facility** *(specify):* |
| **Outpatient Behavioral Health Services**: *(specify):* |

**Enter data at:** [**systemsofcare.ou.edu**](mailto:systemsofcare.ou.edu)**. If you have questions, please email the E-TEAM YIS Help Desk at** [**yis.eteam@ou.edu**](mailto:yis.eteam@ou.edu)**.**