

**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****. If you have questions, please email the E-TEAM YIS Help Desk at** **yis.eteam@ou.edu****.**