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.)

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.