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**.