

Referral Form
Family & Youth Investment

1645 'N' Street • Lincoln, NE 68508 • 402-441-4343 • 402-441-4335 – Fax

Date: _____ Legal guardian informed of this referral? Yes No
First Name: _____ M.I.: _____ Last Name: _____
Address: _____ City _____ State/Zip _____
Phone: _____ E-mail: _____ County of Residence: _____
Date of Birth: _____ Age: _____ Gender: _____ SSN: _____
Primary Caregiver/Legal Guardian: _____ Relationship to youth: _____
Address: _____ Phone: _____
City _____ State/Zip _____ E-mail: _____
Current Living Situation: Home Foster Home Shelter Relative Other: _____
Preferred Language: _____ School: _____ Grade: _____
Referred by (Person/Agency) _____ Phone: _____
Is the youth a ward of the state? Yes No
Does the youth/young adult have a mental health diagnosis? Yes No
If yes, what is the diagnosis and name of clinician: _____

Briefly describe any problems during the last 3 months in the following areas:

School/Work (attendance, grades, specialized classroom or supervision, ability to follow rules)

Home (ability to follow reasonable rules/chores at home, verbal/physical acting out, runaway)

Community/Legal (including legal infractions, arrests, convictions, probation, dangerous behaviors)

Behavior Toward Others (poor social interactions, mean to people or animals, bullying, fighting)

Moods & Emotions (frequency and severity of depression, anxiety, low self-worth, fears, mood swings)

Self-Harm (any self-harm behaviors or suicidal thoughts or behaviors)

Substance Use (frequency and severity of alcohol or drug use)

Thinking (any unusual thinking or communication problems including hallucinations, paranoia, non-verbal)

Services already in place for participant and family:

Recent referrals to community supports:

FYI USE ONLY (Entered into Fidelity EHR Yes)

Outcome of Referral: Screening TAY Review Referral to Community Services

Scheduled Screening Date: _____

If Applicable, TAY Review Meeting Date: _____

X:\FYI\EHR\FORMS\FYI Referral