Region V Systems
Family & Youth Investment Referral Form
1645 'N' Street • Lincoln, NE 68508 • 402-441-4343 • Fax 402-441-4335

Date: _____
Youth/Young Adult Name: _____
Date of Birth: _____ Age: _____ Gender: _____ SSN: _____
Address: _____
City: _____ State/Zip: _____ County of Residence: _____
Phone: _____ E-mail: _____
School: _____ Grade: _____ Preferred Language: _____
Current Living Situation: ☐ Home ☐ Relative ☐ Homeless ☐ Shelter ☐ Other: _____
Caregiver/Legal Guardian: _____ Relationship to youth: _____
Address: _____
City: _____ State/Zip: _____ Phone: _____
E-mail: _____ Legal guardian informed of this referral? ☐ Yes ☐ No
Referred by (Person/Agency): _____
Phone: _____ E-mail: _____

To be eligible for the program the youth/young adult must: be under the age of 25; have a current mental health diagnosis or be willing to complete an evaluation to indicate a diagnosis; not be a state ward at the time of referral; and be at risk for involvement in the juvenile justice system which may include committing a criminal offense or exhibiting behavioral health problems at home or at school.

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 in place or recent referrals to community support for youth/young adult: _____

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:** _____