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:				
			Preferred Language:	
Current Living Situation: ☐ H	lome □ Relative □	Homeless □ Sh	elter 🗆 Other:	
Caregiver/Legal Guardian:			Relationship to youth:	
Address:				
City:	State/Zip	p:	Phone:	
E-mail:			Legal guardian informed of this referral? ☐ Yes	□ No
Referred by (Person/Agency):				
Phone:	E-mail:			
To be eligible for the progra	m the youth/young	g adult must: be	under the age of 25; have a current mental health	
diagnosis or be willing to com	plete an evaluation	to indicate a dia	gnosis; not be a state ward at the time of referral; a	and be
at risk for involvement in the	juvenile justice syst	em which may i	nclude committing a criminal offense or exhibiting	ŗ
behavioral health problems at	home or at school.			
Does the youth/young adult clinician:		_	I Yes □ No If yes, what is the diagnosis and na	ıme of
Briefly describe any problem	ns during the last 3	3 months in the	following areas:	
School/Work (attendance, gra	ades, specialized cla	assroom or super	vision, ability to follow rules)	
Home (ability to follow reaso	nable rules/chores a	nt home, verbal/p	hysical acting out, runaway:	
Community/Legal (including	legal infractions a	rrests conviction	ns, probation, dangerous behaviors)	
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Behavior Toward Others (po	oor social interactio	ns, mean to peop	ole or animals, bullying, fighting)	
Moods & Emotions (frequen	cy and severity of d	epression, anxie	ty, low self-worth, fears, mood swings)	
Self-Harm (any self-harm bel	naviors or suicidal t	houghts or behav	viors)	
Substance Use (frequency and	d severity of alcoho	ol or drug use)		
Thinking (any unusual thinki	ng or communication	on problems incl	uding hallucinations, paranoia, non-verbal)	
Services in place or recent re	eferrals to commu	nity support for	youth/young adult:	
FYLUSE ONLY: Entered into Fig.	delity EHR □ Ves Out	come of Referral	☐ Screening ☐ TAY Review ☐ Referral to Community Serv	ices
Scheduled Screening Date:			e, TAY Review Meeting Date:	