

**Chisholm Trail Systems of Care  
Referral Form  
(Garfield and Kingfisher Counties)  
Fax: 405-375-6367 Attn: Rondi**

Referring Agency: \_\_\_\_\_ Date of Referral: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Referring Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Original referral source, if different from above: \_\_\_\_\_

**Youth Information**

Name: \_\_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_

Race/Ethnicity: \_\_\_\_\_ Sex: \_\_\_\_ School: \_\_\_\_\_ School Phone: \_\_\_\_\_

Caregiver Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Indicate if the youth is:**

DHS:  Involved  In custody DHS worker/phone: \_\_\_\_\_ / \_\_\_\_\_

OJA:  Involved  In custody OJA worker/phone: \_\_\_\_\_ / \_\_\_\_\_

In substance abuse or mental health treatment  Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

Receiving other services (specify): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

On medications (please list): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Initial Screening – Please check all that apply**

- The youth has behavioral/emotional symptoms that suggest a diagnosable emotional disorder.
- The youth has a significant difficulty that has lasted or is expected to last for a year or more due to her/his serious emotional disturbance.
- The youth needs, has received or has requested services or support from two or more systems.
- The youth is at risk of out-of-home placement or out-of-school placement due to the impact of the serious emotional and/or behavioral disturbance.
- The youth and her/his parent, guardian or foster parent resides in a county served by the Oklahoma Systems of Care Initiative.
- The family volunteers for this service and agrees to participate actively.

**General mental health / diagnosis comments**

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**Risk Factors** *(please check all that apply)*

**Youth Factors**

Runaway / leaving home without permission

Chronic illness

Withdrawal from family, social activities

Self-abusive behavior

Recent dramatic changes in eating habits, sleep pattern or body weight

Repeated incidents of lying, stealing, property destruction

Age or developmentally inappropriate bed-wetting or soiling

Physical aggression toward authority figures, family members, peers

Inappropriate sexual behavior

Intentionally hurts others

Perpetrator of sexual abuse

Intentionally hurts animals

Victim of sexual abuse

Sets fires

Victim of physical abuse

Involvement in criminal activity

Use or abuse of alcohol or drugs

Declining school grades, truancy, poor attendance

Attempted suicide or suicidal thoughts

School suspensions / expulsions

Hallucinations – aural, visual or tactile

Developmental delays

History of inpatient psychiatric hospitalization(s)

History of neglect

**Caregiver / Family Factors**

- |  |   |
|--|---|
| <input type="checkbox"/> Chronic physical illness in family<br><br><input type="checkbox"/> Family history of mental illness, psychiatric hospitalization or substance abuse<br><br><input type="checkbox"/> Family member(s) had suicide attempts<br><br><input type="checkbox"/> Family member(s) was victim of physical abuse<br><br><input type="checkbox"/> Family member(s) was victim of sexual abuse | <input type="checkbox"/> Parental incarceration<br><br><input type="checkbox"/> History of domestic violence<br><br><input type="checkbox"/> Poverty<br><br><input type="checkbox"/> Other children in foster care<br><br><input type="checkbox"/> Youth exposed to substance abuse in the home |
|--|---|

**Members of the Youth's Household**

Name	Relation to Youth	Age	Name	Relation to Youth	Age

**Other Information**

How can this youth and her/his family benefit from their involvement with Systems of Care? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What other information about the youth and her/his family do you feel would be helpful to Systems of Care staff?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_