

**REGION II HUMAN SERVICES
YOUTH CARE COORDINATION/TRANSITION TEAM
REFERRAL FORM**

110 North Bailey
P.O. Box 1209
North Platte, NE 69103

PHONE: Sarah White (308) 350 - 0678
FAX: (308) 532 - 1157
sarahwhite@r2hs.com

YOUTH INFORMATION

Name: _____ Age: _____ Date of Birth: _____ Gender: _____

Address: _____ City: _____ ZIP: _____

Home Phone: _____ *Soc. Security #: _____ Language: _____

* - Required field

PARENT/GUARDIAN INFORMATION

Name(s): _____

Address: _____ City: _____ ZIP: _____

Daytime Phone: _____ Language Preference: _____

Is the youth a state ward? YES NO (If yes) Guardian Name: _____

Current Diagnosis:

Axis I: _____

Current Mental Health Provider: _____

Is the youth at a high risk of becoming a state ward, committing a criminal offense, dropping or staying out of school or being placed in a home? Yes No

If yes, please explain:

Has the family agreed to referral and to participation in the wraparound process? Yes No

A release of information to Region II Human Services has been secured and attached. Yes No

Signature of Referring Person

Date

Relationship

Phone Number

PROGRAM USE ONLY

Assigned to: _____

Date Received: _____