



Oklahoma Systems of Care Health Home Referral Form

(To be completed by external referring organization)

Date of Referral: ____ / ____ / ____

Person making Referral: _____ Phone: _____

Youth Information

Name: _____ SSN: _____ Medicaid / Member #: _____

Birth Date: ____ / ____ / ____ Gender: ____

Caregiver Name: _____ Relationship to Child: _____

Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Referring Organization and Circumstance (check only one box)

Child Welfare: <input type="checkbox"/> Involved (open CW case) <input type="checkbox"/> In DHS custody
OJA: <input type="checkbox"/> Involved <input type="checkbox"/> In custody
<input type="checkbox"/> Other Law Enforcement (<i>specify</i>): _____
<input type="checkbox"/> Primary Care – If chronic health condition, please specify: _____
School System: <input type="checkbox"/> IEP <input type="checkbox"/> 504 Plan <input type="checkbox"/> Other (<i>specify</i>) _____
<input type="checkbox"/> Inpatient Facility
<input type="checkbox"/> Other referrer: _____

Reason for Referral
