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

110 North Bailey
North Platte, NE 69101

PHONE: Bonnie (308) 539-4065
FAX: (308) 532-1157
Attn: Sarah White

YOUTH INFORMATION

Name: _____ Age: _____ Date of Birth: _____

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: _____

Current Crisis/Stressors:

_____

_____

_____

_____

_____

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:_____