Does child have Medicaid/SoonerCare?
☐ Yes ☐ No
If yes, Medicaid ID: _____

Payne County Youth Services, Inc
Referral Form

Date: _____/_____/_____

Type of Referral (and/or Classes Requested)

Counseling ☐ Parenting ☐ Skills for Success /
AOD Eval ☐ Safe Sitter ☐
(Substance Use Eval) Safe At Home ☐ FTOP: ☐

Please e-mail completed form to:
counselingreferrals@pcys.org
or fax to (405) 377-3499

For any questions, call:
(405) 377-3380

Youth's Last Name:	Youth's First Name:	MI:	Race:	Assigned Sex: ☐ Female ☐ Male

DOB:	Age:	School:	Grade:	Pronouns: ☐ She/her ☐ _____ ☐ He/him

Mailing Address:	City:	County	Zip Code:

Parent / Guardian Name(s):	Phone 1: Whose # is it? _____	Phone 2: Whose # is it? _____

Identifying Message OK? ☐ Yes ☐ No	Parent / Guardian consent for e-mail: ☐ Yes ☐ No	E-mail address:

Best Day(s)/Time(s) to Contact Parent/Guardian?
☐ Mon a.m. ☐ Tues a.m. ☐ Wed a.m. ☐ Thurs a.m. ☐ Fri a.m. ☐ Anytime
☐ Mon p.m. ☐ Tues p.m. ☐ Wed p.m. ☐ Thurs p.m. ☐ Fri p.m. ☐ Other: _____

Would you like to receive appointment reminders? ☐ Yes ☐ No
If yes, preferred method(s) of contact for reminders: ☐ Phone call ☐ Text ☐ E-mail

Name of Person Making Referral / Relationship to Youth:

Referral Source (Please select one)
◯ Family ◯ Court ◯ Doctor (PCP) ◯ Health Dept ◯ Law Enforc. ◯ Safe Place ◯ Self
◯ School ◯ DHS ◯ Friend ◯ Hospital ◯ OJA ◯ Other: _____

REASON FOR REFERRAL: (check all that apply)

☐ Adjustment (to _____)	☐ Emotionally Reactive	☐ Law Violation	☐ Self-Esteem
☐ Anger Management	☐ Fighting	☐ Low Motivation	☐ Self-Harm
☐ Anxiety	☐ Focus / Inattention	☐ Neglect	☐ Sexual Abuse
☐ Awaiting Placement	☐ Grief (Loss / Death)	☐ Parenting Skills / Educ.	☐ Substance Use / Vaping
☐ Bullying	☐ Health / Hygiene	☐ Peer Relationships	☐ Suicidality
☐ Cyber Use / Misuse	☐ Home / Family Difficulties	☐ Physical Abuse	☐ Trauma History
☐ Dating / Relationships	☐ Homeless	☐ Prevention	☐ Truancy
☐ Depression	☐ Homicidality	☐ Risk of Delinquency	☐ Withdrawn / Isolating
☐ Emotional Abuse	☐ Impulsivity	☐ Runaway	☐ _____
	☐ Independent Living	☐ School Problems	☐ _____

Crisis Notification: ***This caller perceives that a crisis exists and requires an immediate response.*** Action to be taken:
(Who) _____ (What) _____ (When) _____

PROBLEM STATEMENT:

_____

_____

_____

_____

☐ **Check if more on reverse.** Referral Counselor Signature _____

PCYS USE ONLY

Case Assigned to:_____ By:_____ Date:_____

I&R Only: Referred To: _____ Reason: _____

Last Name: _____ First Name: _____ MI: _____

UI: _____

Revised 9/9/25

Data Base ID # _____

Payne County Youth Services, Inc.

Last Name: _____ First Name: _____ MI: _____

UI: _____

Revised 5/14/25