Division of Behavioral Health
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Referral for Dane County Youth Connect Program

Submit with Referral to: YouthConnect@countyofdane.com or call: (608) 896-0755

Date of Referral: Person Completing Referral: Contact info:

Relationship to Youth: Is youth/family aware of this referral? ☐ Yes ☐ No

Youth & Family Information:

Youth's Legal Name: Preferred Name: Pronouns:

Birth date: Preferred Language: ☐ Youth Needs Interpreter

Youth's Address: ☐ The youth resides at an out-of-home placement

Parent/Guardian Name:
Address (if different):
Phone: Email:
Preferred Language:
☐ Interpreter Needed

Parent/Guardian Name:
Address (if different):
Phone: Email:
Preferred Language:
☐ Interpreter Needed

Mental Health and/or Substance Use Concerns:

Has the youth been to the ER/had a psychiatric hospitalization in the past 12 months? ☐ Yes ☐ No ☐ Unknown

If yes, what dates were they hospitalized?

Is youth currently hospitalized? ☐ Yes ☐ No Hospital Name: Admission Date:

In the past 12 months has the youth experienced or exhibited any of the following?

☐ Psychosis: Serious mental illness with delusions, hallucinations, and/or lost contact with reality
☐ Suicidality: Suicide attempt in past 12 months or significant suicidal ideation or plan in past month
☐ Violence: Life threatening acts ☐ Recent contact with law enforcement ☐ Jail or detention
☐ Self-harm behaviors: Example: Cutting, burning, hitting, pulling out hair, scratching oneself

If yes, please describe:

Please describe primary mental health/substance use concerns for which youth/family is seeking services:

If known, please list MH/SU diagnoses:

Immediate Supports Needed:

☐ Therapist ☐ Family/Parent Peer Support ☐ MH System Navigation ☐ Discharge Planning
☐ Psychiatry ☐ Psychological Evaluation for MH/SU diagnosis ☐ Crisis Planning ☐ Other

Current Services and Treatment Providers:

School Supports:

Current school: Grade:

☐ IEP ☐ 504 ☐ Building Bridges ☐ School-based therapist

Primary contact: Phone/Email:

Please indicate if the youth has the following supports:

Current Therapist: ☐ Yes ☐ No ☐ Waitlist
Enrolled in CCS: ☐ Yes ☐ No ☐ Waitlist
Enrolled in CLTS: ☐ Yes ☐ No ☐ Waitlist

If yes, please provide primary contact information for services:

Name & Agency: Contact Information:
Name & Agency: Contact Information:

Health Insurance:

☐ None ☐ Medicaid/BadgerCare ☐ Katie Beckett Waiver ☐ Private/HMO

Policy# Subscriber Number #:

Current Legal Systems Involvement:

☐ None ☐ CPS ☐ Justice ☐ Chapter 51 ED ☐ Other:

Social Worker Name / Contact Information:

If there are any additional significant stressors or needs experienced by the youth/family, please describe:
(Examples: history of abuse/neglect, loss of a parent, exposure to violence, bullying, divorce, discrimination)