TAMMIRA

Date: _____

Youth Referral Form

IMPORTANT NOTICE

This referral form may only be completed by school staff or by affiliates of TAMMIRA partner organizations.

Do not refer youths who may be experiencing acute psychosis, risk of harm to self (suicidal) or others (homicidal), or an immediate crisis. Instead, please call 988 immediately.

TAMMIRA offers support through psychoeducation and early prevention screenings. Our registered nurses provide education on topics like mental wellness, diabetes management, and medication safety. We do not diagnose conditions, prescribe medication, or provide treatment.

What is your source of referral?

☐ School _____ ☐ Hospital/Clinic _____ ☐ Organization _____

Youth's Information

Youth's Full Name _____

Date of Birth _____

Grade _____ Student ID _____

Email Address _____

Phone Number _____

What kind of phone or device does the youth use?

☐ iPhone or iPad ☐ Android/mobile device ☐ No mobile phone ☐ Don't know

For identification purposes, please attach a scanned copy of the youth's photo ID. If you don't have a photo at this time, please email one to wellness@tammira.com and write Youth Photo ID in subject line.

Insurance Information

☐ No Insurance ☐ Private Insurance ☐ Medi-Cal ☐ Out-of-Pocket ☐ Don't know

*Uninsured youths can still participate in live group events

Parent or Legal Guardian Contact

Full Name _____

Email Address _____

Phone Number _____

Residential Address _____

Relationship to Child _____

Preferred Language _____

Emergency Contact Name _____ Phone Number _____

School Information

School Name _____

School Address _____

School Emergency Contact Name _____ Phone Number _____

Hospital Information

Hospital Name _____

Hospital Address _____

Hospital Emergency Contact Name _____ Phone Number _____

Referrer Information

Your Full Name _____

Your Email Address _____

Phone Number _____

Affiliated Partner Organization (if applicable) _____

Your Role _____

Additional Details:

☐ I confirm I have the legal authority to refer this youth.

Does the youth know they're being referred?

☐ Yes
☐ No
☐ Other: _____

Who's the best person at the school/hospital/clinic/organization to contact for follow-up?

Name _____ Phone Number _____

Email Address _____

Which areas does this referral relate to? (Check all that apply)

☐ **Mind & Emotions (Mental Wellness)**

- ☐ Anxiety
- ☐ Substance use
- ☐ Depression
- ☐ Disordered eating
- ☐ Other mental health concerns: _____

☐ **Body & Health (Physical Wellness)**

- ☐ Fitness
- ☐ Sleep routine
- ☐ Nutrition
- ☐ Diabetes
- ☐ Medications
- ☐ Other: _____

☐ **Strengths & Growth (At-Promise)**

- ☐ Foster
- ☐ Unhoused
- ☐ Probation
- ☐ Other: _____

☐ **Identity & Self-Care (Sense of Self)**

- ☐ Self-esteem
- ☐ Skincare
- ☐ Hygiene
- ☐ Other: _____

☐ **Friendships & Relationships**

- ☐ Healthy boundaries
- ☐ Peer support
- ☐ Romantic relationships
- ☐ Other: _____

☐ **Communication**

- ☐ Pro-social behavior
- ☐ Family relationships
- ☐ Other: _____

☐ **Guidance & Support (Mentorship/Trusted Adult)**

- ☐ Parenting
- ☐ Mentoring
- ☐ Other: _____

☐ **Technology**

- ☐ Excessive Social Media Usage
- ☐ AI Dependency
- ☐ Gaming Addiction
- ☐ Sexortion/Grooming
- ☐ Cyberbullying
- ☐ Other: _____

IMPORTANT NOTICE
This referral form is not for crisis situations. If the youth is experiencing acute psychosis, homicidal thoughts, or suicidal intent, please call 988 immediately.