

Behavioral Health Referral Form

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DATE OF REGISTRATION

Please fill in all required parts. Once you complete this form, please email it to referrals@atlanticstreet.org with "Referred Name - BH Referral Form" as the subject.

Is the person in need of care a resident of King County/Settle? (Required)

•		
O Yes		
O No		

DEMOGRAPHICS

Please tell us about the person needing care.

Name of Person Needing Care (Required) First Last

ProviderOne ID:

Date of Birth: (Required) Current Age: (Required)

Please enter birth date as MM-DD-YYYY

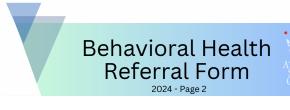
Please note the person in need of care must be between the ages of 5 and 26.

Address of person needing care			
Street Address: (Required)			
Unit Number:	City: (Required)		
Zip Code: (Required)			
Preferred phone number & OK to leav	re a message on (Required)		
	O Home O Cell O Work		
Email:	Alternate Phone Number		
l			
Family Size:	Primary language spoken a	t home:	
Others in home and ages:	Interpreter needed? (Required	Yes O No	
Name of Parent/Primary Caregiver (Required)	Is this their legal guardian?	Relationship to Person Seeking Care:	
	O Yes O No	O Legal Guadian	
If 18 or over, please put "n/a."		O Mother	
If Parent/Primary Caregiver is not their legal		O Father	
guardian, please enter that name.	5	O Grandparent	
		O Other	

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- O Yes
- O No
- O Unsure

Not Applicable





School:	Grade: School Phone:	
Main School Contact:	Special Ed?	
	O No O Not Applicable	
School District:		

Please type in the district in which the person needing care attends school.

PRESENTING ISSUES

Please describe the issues the person is seeking treatment for.

Major Presenting Issues (Required)

Suicidal Ideations
Self-Harm
Hospitalizations
School Suspension
None of the above

Please describe major presenting issues. (Required)

Substance abuse. (Required)

Alcohol, marijuana, nicotine, misc. drugs, gambling, etc. If none, write "none".

ADA accommodation needs.

If none need, write "none" or "n/a."

Needed Services (Required)

Check all that apply.

- Individual Counseling
- Family Counseling
- Case Management
- School Support
- Medication Management
- Social Skills
- Parenting Support
- Domestic Violence Support
- Social & Recreation
- Adult Outpatient Services

REFERRAL SOURCE

Please tell us who is referring the person needing care.





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Name of Person N First	Needing Care (Required Last			
Phone Number fo	or Referrer (Required)			
Email Address (Re	quired)	Name of Referring Organizat	ion (Required)	
Address of Refer	ring Organization			
Street Address: (Required)				
Address Line 2:		City: (Required)		
State: (Required)		Zip Code: (Required)		
	eferred Person (per ardian is Informed c	son needing care) (Required) of Referral (Required)		
Parent/Legal Gua Yes No Not Applicable	ardian Agrees with I	Referral (Required)		
Parent/Legal Gua Yes No Not Applicable	ardian Wants/Need	Is to be Contacted (Required)		

Once you have completed and saved this form, please email to referrals@atlanticstreet.org. We recommend having the email subject be "Referred Name - BH Referral Form."

Retain a copy for your records.