# 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)*

- [ ] Yes
- [ ] No

## DEMOGRAPHICS

Please tell us about the person needing care.

**Name of Person Needing Care** *(Required)*

First

Last

**ProviderOne ID:**

**Date of Birth:** *(Required)*

***Please enter birth date as MM-DD-YYYY***

**Current Age:** *(Required)*

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 leave a message on** *(Required)*

- [ ] Home
- [ ] Cell
- [ ] Work

**Email:**

**Alternate Phone Number**

**Family Size:**

**Primary language spoken at home:**

**Others in home and ages:**

**Interpreter needed?** *(Required)*

- [ ] Yes
- [ ] No

**Name of Parent/Primary Caregiver** *(Required)*

*If 18 or over, please put "n/a."*

**Is this their legal guardian?**

- [ ] Yes
- [ ] No

**Relationship to Person Seeking Care:**

- [ ] Legal Guadian
- [ ] Mother
- [ ] Father
- [ ] Grandparent
- [ ] Other

*Other*

**If Parent/Primary Caregiver is not their legal guardian, please enter that name.**

**Medicaid Eligible?**

- [ ] Yes
- [ ] No
- [ ] Unsure
- [ ] Not Applicable

**School:**

**Grade:**

**School Phone:**

**Main School Contact:**

**Special Ed?**

- [ ] Yes
- [ ] No
- [ ] 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.

**Name of Person Needing Care** *(Required)*

First

Last

**Phone Number for Referrer** *(Required)*

**Email Address** *(Required)*

**Name of Referring Organization** *(Required)*

**Address of Referring Organization**

**Street Address:** *(Required)*

**Address Line 2:**

**City:** *(Required)*

**State:** *(Required)*

**Zip Code:** *(Required)*

**Relationship to Referred Person (person needing care)** *(Required)*

**Parent/Legal Guardian is Informed of Referral** *(Required)*

- [ ] Yes
- [ ] No
- [ ] Not Applicable

**Parent/Legal Guardian Agrees with Referral** *(Required)*

- [ ] Yes
- [ ] No
- [ ] Not Applicable

**Parent/Legal Guardian Wants/Needs to be Contacted** *(Required)*

- [ ] Yes
- [ ] No
- [ ] Not Applicable

***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.***