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**DATE OF REGISTRATION** 

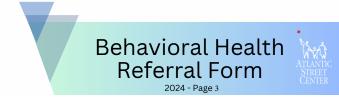
Please fill in all required parts. Once you complete this form, please email it to referrals@atlanticstreet.org with "Referred Name - BH Referral Form" as the subject.

Is the person in need of care a reside	ent of King County/Settle? (Required)	
○ Yes		
O No		
DEMOGRAPHICS		
Please tell us about the person needing o	care.	
Name of Person Needing Care (Re	I I	ProviderOne ID:
Date of Birth: (Required)	Current Age: (Required)	
Please enter birth date as MM-DD-YYYY		06
Address of person needing care	need of care must be between the ages of 5 and 2	20.
Street Address:		
(Required)		
Unit Number:	City: (Required)	
Zip Code: (Required)	(nequined)	
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? (Require	ed) O Yes O No
Name of Parent/Primary Caregiv	ver Is this their legal guardian?	Relationship to Person Seeking Care:
(neganca)	Yes O No	C Legal Guadian
If 18 or over, please put "n/a."		Mother Mother
If Parent / Primary Carogiyor is no	at their legal	Father
If Parent/Primary Caregiver is no guardian, please enter that name	_	Grandparent
gaaraian, prouse enter that hanne	<u>.</u>	Other
		Other

Medicaid Eligible?		V V	Behavioral Health
O Yes			Referral Form
O No			2024 - Page 2
Unsure			
Not Applicable			
School:	Grade:	School Phone:	
Main Calle al Cauda at			
Main School Contact:	Special Ed?  Yes  No  Not Applie		
School District:			
Please type in the district in which the person needing care a	ttends school.		
A series of the			
PRESENTING ISSUES			
Please describe the issues the person is seeking	g treatment for		
Major Presenting Issues (Required)  Suicidal Ideations  Self-Harm  Hospitalizations  School Suspension  None of the above	Please des	cribe major prese	enting issues. (Required)
Substance abuse. (Required)			odation needs.
Alcohol, marijuana, nicotine, misc. drugs, gambling, etc. If n	one, write "none".	If none need, write "r	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 (Re First	quired) Last			
Phone Number for Referrer (Required)				
Email Address (Required)	Name of Referring Organization (Required)			
Address of Referring Organizatio	n			
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 Inform	ed of Referral (Required)			
O No				
Not Applicable				
Parent/Legal Guardian Agrees w  Yes	ith Referral (Required)			
○ No Not Applicable				
Parent/Legal Guardian Wants/N  O Yes	eeds to be Contacted (Required)			
O 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.

**Administration Notes:**