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)* __ __ / __ __ / __ __ **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)*

BH Referral Form

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 Referrer *(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.