



## Behavioral Health Referral Form

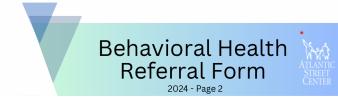
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Please fill in all required parts. Once you comple		DATE OF REGISTRATION
Is the person in need of care a resident  Yes		
DEMOGRAPHICS Please tell us about the person needing care		
Name of Person Needing Care (Require		ProviderOne ID:
Date of Birth: / / / / / / / / / / / / / / / / / / /	Current Age: (Required)	
Address of person needing care Street Address:  (Required)	of care must be between the ages of 5 and	26.
Unit Number:  Zip Code: (Required)	City: (Required)	
Preferred phone number & OK to lea	ave a message on (Required)  O Home O Cell O Work	•
Email:	Alternate Phone Number	
Family Size:	Primary language spoken	at home:
Others in home and ages:	Interpreter needed? (Requir	ed) O Yes O No
Name of Parent/Primary Caregiver (Required)	Is this their legal guardian?	Relationship to Person Seeking Care:  Legal Guadian  Mother
If 18 or over, please put "n/a."  If Parent/Primary Caregiver is not the guardian, please enter that name.	neir legal	Father Orandparent Other Other

Medicaid Eligible?  Yes  No  Unsure			Behavioral Health Referral Form
O Not Applicable			
School:	Grade:	School Phone:	
Main School Contact:	Special Ed? O Yes O No O Not Applic	ablo	
School District:		able	
Please type in the district in which the person needing care a	ttends school.		
PRESENTING ISSUES  Please describe the issues the person is seekin	g treatment for.		
Major Presenting Issues (Required)  Suicidal Ideations  Self-Harm Hospitalizations School Suspension None of the above	Please dese		enting issues. (Required)
Substance abuse. (Required) Alcohol, marijuana, nicotine, misc. drugs, gambling, etc. If n	one, write "none".	ADA accomm	odation needs. 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 Referrer First	<i>(Required)</i> Last		
FIISL	LdSt		
Phone Number for Refer	rer (Required)		
Thome Number for Kerel	Tel (regards)		
Email Address (Required)	Name of Refe	erring Organization (Required)	
Address of Referring Org	ganization		
Street Address: (Required)			
Address Line 2:		City: (Required)	
State: (Required)		Zip Code: (Required)	
Relationship to Referred	l Person (person needing car	(Required)	
Parent/Legal Guardian  Yes  No	is Informed of Referral (Require	ed)	
O Not Applicable			
Parent/Legal Guardian A  Yes  No  Not Applicable	Agrees with Referral (Required)		
Parent/Legal Guardian V O Yes O No O Not Applicable	Wants/Needs to be Contacte	ed (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."