



# 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 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 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 Guardian  
 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

# Behavioral Health Referral Form

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### 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 Making Referral

(Required)

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](mailto:referrals@atlanticstreet.org). We recommend having the email subject be "Referred Name - BH Referral Form."***

***Retain a copy for your records.***

Administration Notes: