



Behavioral Health Referral Form

2026 - Page 1

(* = Required)

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.

DATE OF REGISTRATION*

Is the person in need of care a resident of King County/Seattle?*

- Yes
 No

REFERRED INDIVIDUAL INFORMATION

Please note the person in need of care must be between the ages of 5 and 26.

Name of Person Needing Care*

First

Last

ProviderOne ID:

Date of Birth*:

Current Age*:

Medicaid Eligible?

- Yes
 No
 Unsure
 Not Applicable

Address of person needing care:

Street Address* :

Unit Number:

Zip Code*:

City*:

Cell Phone :

Enter contact information for **individuals age 13+**. use section below for Parent/Guardian information.

Email:

Family Size:

Primary language spoken at home:

Others in home and ages:

Interpreter needed?*

- Yes No

PARENT/GUARDIAN INFORMATION

Name of Parent/Primary Caregiver

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

Is this their legal guardian?

- Yes No

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

Cell Phone :

Email:

Relationship to Person Seeking Care:

- Legal Guardian
 Mother
 Father
 Grandparent
 Other

Other

(* = Required)

SCHOOL INFORMATION

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*:

- Suicidal Ideations
- Self-Harm
- Hospitalizations
- School Suspension
- None of the above

Please describe major presenting issues*:

Services Requested*:

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

Substance abuse*:

Alcohol, marijuana, nicotine, misc. drugs, gambling, etc. If none, write "none".

ADA accommodation needs:

REFERRAL SOURCE

Please tell us who is referring the person needing care.

Name of Referrer:*

First Last

(* = Required)

Phone Number for Referrer*:

Email Address*:

Name of Referring Organization*:

Address of Referring Organization:*

Street Address:

Address Line 2:

City:

State:

Zip Code:

Relationship to Referred Person (person needing care)*:

REFERRAL NOTIFICATION & AGREEMENT

Youth (age 13+) is informed of Referral?*

- Yes
 No
 Not Applicable

Parent/Legal Guardian is Informed of Referral?*

- Yes
 No
 Not Applicable

Parent/Legal Guardian Agrees with Referral?*

- Yes
 No
 Not Applicable

Parent/Legal Guardian Wants/Needs to be Contacted?*

- Yes
 No
 Not Applicable

Once you have completed and saved this form, please send via secure email to referrals@atlanticstreet.org. We recommend having the email subject be "Referred Name - BH Referral Form."

Retain a copy for your records.