

**REFERRAL**

**Lutheran Community Services – Children’s Intensive Services**

**FAX 509-783-2089 PHONE 509-783-2085**

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| --- | --- |
|  Name of Youth: | Date of Referral: |
| Parent: | Ethnicity: | Date of Birth: |
| Address: | Gender: | Age: |
| City: | State: | Zip: | Preferred LanguageYouth: | Parent: |
| Family Phone: | Program RequirementMEDICAID enrolled | Provider 1#: |
| Person Making Referral: | Referral Contact Phone: |
| Agency or relationship to youth: |
| Purpose of Referral: |
| List the Agency/Team Members who met with family and agree to referral: |
| May we contact the family directly regarding this referral? If yes, please have ROI on page 2 signed by appropriate individual | YES [ ]  | NO [ ]  |
| Youth Status: Lives with: Biological Family [ ]  Adopted [ ]  Foster Care (Supervised) [ ]  |
| Involved Parents/Guardians/Caregivers |
| Name: | Name: |
| Address: | Address: |
| City: | State: |
| Phone: | Phone: |  | City: | State: | Zip: |
| **Legal Guardians** |
| Name: | Address: |
| Phone: | City: | State: | Zip: |
| **Siblings** |
| Name | Age | Where do they live? |
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| **Strengths/Interests/Resources of Youth and Family** |
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| **Current Needs/Concerns of Youth and Family** |
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| **Legal Issues Regarding Youth** |
| Truancy YES [ ]  NO [ ]  | Diversion YES [ ]  NO [ ]  | Youth at Risk YES [ ]  NO [ ]  | PO: |
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| **Education Status of Youth** |
| School: | Grade: | Attendance: YES [ ]  NO [ ]  | Current IEP or 504YES [ ]  NO [ ]  |
| School Concerns: |
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| **Diagnosis – including DSM V/ICD-10 codes** |
| Primary: | Secondary: |
| Tertiary: | Quaternary: |
| As diagnosed by:  |
| **Medications** |
| Is the youth currently taking medication YES [ ]  NO [ ]  | Prescriber: | Compliant:YES [ ]  NO [ ]  |
| **Services received in the past 12 months** |
| **Therapy/Case Management** TCCH [ ]  Lourdes Counseling [ ]  Catholic Charities [ ]  Other [ ] Provider**:** |
| **Hospitalization** | Date: | Location: |
| **Hospitalization** | Date: | Location: |
| **SUD** | Date: | Location: |
| **CPS** | Active YES [ ]  NO [ ]  | Caseworker: |
| **Out of Home Placements** |
| Description: | Date: |
| Description: | Date: |
| Description:  | Date: |
| **Additional Comments Regarding Youth and Family** |
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| I authorize the Release and Exchange of Information to CIS - Lutheran Community Services that is needed for the purpose of referral for the above named person. |
|  ROI effective date: | Until (60 days if no date) |
| SignatureParent/Guardian or Client if over 13 | Date: |
| This information has been disclosed to you from records the confidentiality of which may be protected by federal or state law. If the records are so protected, Federal Regulation (42CFR Part 2) prohibits you from making any further disclosure of this information, unless disclosure is expressly permitted by 42CFR Part 2, and pursuant to WA State RCW 70.02 and HIPAA.A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.This authorization may be revoked at any time by notifying CIS-LCS in writing, except to the extent that action has already been in reliance on it. |