LUTHERAN Community Services NORTHWEST

Child, Youth, and Teen Referral Form

Please complete page 1 & 2
fax form to: Intake & Referral @ (503) 352-1088

Date of Referral:_____

- Name/Preferred name of child, youth, or teen:

  _____

  - Child, youth, or teen phone #:_____
  - Risk of harm to self or others? Yes ☐ No ☐
    - Please explain:

      _____
  - Email:_____ Voicemail OK? Yes ☐ No ☐
  - DOB:_____ Gender/Preferred Pronouns:_____
  - Address:_____
  - Country of origin:_____ Interpreter? Yes ☐ No ☐
  - Language(s) spoken:

    _____
  - OHP #:_____
  - What are the best days/times the client will be available to meet with a therapist?

_____

- Name of school:_____ Grade:_____

- Name/Preferred name of caregiver:

_____

- Caregiver/family member's phone #:_____
- Email:_____ Voicemail OK? Yes ☐ No ☐

- Is client ready to be on a waitlist for 2-4 weeks? _____
- Referent name and role:_____
- Referent phone #:_____

  Email:_____
- Does the child or caregiver know about the referral?_____
- Reason for the referral:

_____

_____