LUTHERAN Community Services NORTHWEST

Lutheran Community Services – WISe Referral Form Please submit all referrals here: https://forms.gle/1nHwPpTxgm4EuDB9A

Youth MUST have an Active Provider One # (Medicaid/Apple Health)

Name of Youth:			Date of Referral:		
Parent:			Ethnicity:	Date of Birth:	
Address:			Gender:	Age:	
City:	State:	Zip:	Preferred Language Youth:	Parent:	
Family Phone:			Program Requirement MEDICAID enrolled	Provider 1#:	
Family Email:					
Person Making Referral:			Referral Contact Phone:		
Agency or relationship to youth:					
Agency contact E-mail:					
Purpose of Referral:					
Youth Lives with: Biological Family ☐ Adopted ☐ Foster Care (Supervised) ☐ BRS ☐ VPS ☐					

Involved Parents/Guardians/Caregivers					
Name:			Name:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Hm Phone:	Cell Phone:		Hm Phone:	Cell Phone:	

Legal Guardians			
Name:		Address:	
Phone:		City:	State: Zip:

Siblings currently enrolled in WISe			
Name	Age	Name	Age

Current Needs/Concerns of Youth and Family

Legal Issues Regarding Youth			
Truancy YES ☐ NO ☐	Diversion YES ☐ NO ☐	Youth at Risk YES ☐ NO ☐	Pending Charges YES ☐ NO ☐
More information			
Probation Officer			

Education Status of Youth			
School:	Grade:	Attendance: YES ☐ NO ☐	Current IEP or 504 YES ☐ NO ☐

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 ☐ Therapist Name**:**		
Hospitalization	Date:	Location:
Hospitalization	Date:	Location:
SUD	Date:	Location:
CPS	Active YES ☐ NO ☐	Caseworker:

Out of Home Placements	
Description:	Date:
Description:	Date:

INFORMED CONSENT

I authorize the Release and Exchange of Information to Lutheran Community Services that is needed for the purpose of referral for the above named person. Typing your name in the signature box and submitting this document indicates your agreement to share information.

Consent effective date:

Signature Parent/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 LCS in writing, except to the extent that action has already been in reliance on it.

Informed Consent for Telehealth Services

Lutheran Community Services Northwest (LCSNW) knows that there are times when you or your provider may not be able to engage in face-to-face health care services. We are committed to continuing to serve you during those times through the provision of telehealth services.

Description of Telehealth Services: "Telehealth" refers to services that can either occur over the phone, or "telephone services," and services that can only occur when you and your provider can see each other via video technology and can communicate back and forth in real time, or "telemedicine services."

For all telehealth services (telephone and telemedicine):
1. Your provider will always be in a secure and private location to provide telehealth services. You must also be aware of your surroundings when telehealth services are provided to you. It is your responsibility to choose a location where your conversations with your provider cannot be overheard by others.
2. Standard data and message rates will apply. LCSNW will not reimburse you for the costs of telehealth services.
3. You release LCSNW from all claims, damages, losses, and expenses arising out of your failure to use a secure location and method of communicating with LCSNW while engaging in telehealth services, including but not limited to your use of an unsecure wifi connection.

For telemedicine (video services) only:
4. LCSNW will provide you with a link and a phone number that you can use to join the telemedicine session. LCSNW will send you this information via the email address or text number that you provide below.
5. The video link is a secure method of delivery. In order to maintain the full security of the connection, you need to connect to the session using a phone or using a secure wifi network. This means that the wifi network that you use must require a password that is not publicly available or publicly displayed.

Anticipated Results and Benefits of Telehealth Services: The anticipated results and benefits of telehealth services are to effectively and efficiently assist you with the care, management, and treatment of your health condition(s).

Potential Risks: As with any medical service, there are potential risks associated with the use of telehealth. These risks include, but are not be limited to, delays in treatment due to failures of telehealth software or equipment. Also, security protocols could fail, causing a breach of privacy of your medical information.

Alternatives: Alternatives to telehealth include face-to-face services from a provider or not receiving any treatment. However, providers who may be able to meet face-to-face with you may not have the same expertise as a remote telehealth provider. Additionally, your choice not to receive any treatment could make your health condition(s) worse.

Text and Phone Call Consent: By your signature below, you consent to LCSNW's transmission of calls and unencrypted text messages at the cell number below, and unencrypted email messages at the email address below, related to the telehealth services. Unencrypted communications carry certain risks. For example, text messages and emails could be received by other people who have access to your device.

By your signature below, you acknowledge that these risks exist and expressly consent to receive unencrypted communications described in this Consent from LCSNW.

Cell number: _____ **Email address:** _____

By my signature, I, the client designated below, understand the above description of the telehealth services, the potential benefits and risks of telehealth, and the possible treatment alternatives. I certify that I have had the opportunity to ask questions and consent to receiving telehealth services from LCSNW.

Client Name _____

Signature_____ **Date** _____

Name/Relationship of Authorized Signer (if other than client): _____