LUTHERAN Community Services NORTHWEST

ONLINE REFERRAL
Lutheran Community Services Northwest
PHONE 509-735-6446
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.