SOUTHEAST YOUTH AND FAMILY SERVICES
REFERRAL FORM
Phone: 206-721-5542 Fax: 206-721-5917

Person making referral: _____ Relationship to client/agency: _____

Referral phone number: _____ Date of referral: _____

Name of prospective client: _____ DOB/age: _____

Address: _____ Zip code: _____

Is client aware of referral? Yes ☐ No ☐ Does the person have Medicaid? Yes ☐ No ☐

Does the person have commercial insurance: Yes ☐ No ☐ If yes, type:_____

Ethnicity: _____ Preferred language: _____

Gender identity: ☐M ☐F ☐_____ Contact for client: _____

Guardian(s): _____ Guardian's phone number: _____

Have guardians been notified? Yes ☐ No ☐ Okay to contact guardian? ☐Yes ☐No

School youth attends: _____ Grade: _____

GENERAL NATURE OF ISSUES (CHECK ALL THAT APPLY)

☐ **Emotional Issues:** _____
☐ **Family Problems:** _____
☐ **Behavior Problems**
- ☐Anger Outbursts
- ☐Defiant Behavior
- ☐Violent/Aggressive Acts

☐ **Abuse Suspected**
- Reported to CPS: ☐Yes ☐No Date(s): _____
- ☐Emotional
- ☐Physical
- ☐Sexual

☐ **History of Mental Illness**
- ☐Diagnosis: _____

☐ **Suicide**
- ☐Ideation Date(s) _____
- ☐Threats Date(s) _____
- ☐Attempts Date(s) _____
- ☐Self-harm Date(s) _____

☐ **Runaway**
☐ **Prostitution Involvement**

☐ **Social Problems**
- ☐Rule-breaking
- ☐Social Skills Deficit

☐ **School Problems**
- ☐Attendance
- ☐Acting Out
- ☐Peer Problems
- ☐Teacher/Authority Issues
- ☐Academic

☐ **Substance Abuse**
- ☐Youth
- ☐Family

☐ **Legal Problems**
- ☐Probation

☐ **Pregnancy**
☐ **Health Issues:** _____

ADDITIONAL COMMENTS/BRIEF NOTES

_____

_____

OFFICE USE ONLY

☐New ☐Re-open Transferred From: _____ Medicaid: ☐Yes ☐No

Signature of Intake Person: _____ Date: _____

PIC ID#: _____ Case has been assigned to:_____ Date: _____