

CHILD, YOUTH, AND FAMILY **MENTAL WELLNESS**

CYF 4033 76TH PL NW 4038 76TH PL NW TULALIP, WA 98271 € (360) 716-4224 ➡ (360) 716-0751 CAC 2321 MARINE DR TULALIP, WA 98271 (360) 716-5437 (360) 716-0852

TULALIP HEALTH SYSTEM

BEHAVIORAL HEALTH & RECOVERY

HEALTH CLINIC 7520 TOTEM BEACH RD TULALIP, WA 98271 (360) 716-4511 (425) 259-8626

BJTELA 7607 TOTEM BEACH RD TULALIP, WA 98271 (360) 716-4250 (360) 716-0811

Request for Services (Youth Referral)

By completing this form you are agreeing to the following: I am at least 13 years of age and completing this form on behalf of myself, or I am the parent and/or legal guardian of a youth less than 18 years of age.

Today's Date: / /			
INFORMATION REGARDING THE INDIVIDUA	L COMPLETING REQUEST (Other than legal guardian)		
Name:	Relationship to youth:		
Phone #: () -	Phone Type: O Home O Cell O Work		
YOUTH	INFORMATION		
Full Legal Name: [FIRST] [MID	DLE] [LAST]		
Nickname (if applicable):	Date of Birth: / / Age:		
Gender: OFemale OMale OTransgender Female	Transgender Male Other/Non-binary Chose not to disclose		
Interpreter needed? O Yes O No	If yes, language:		
Youth's Address: [STREET]			
[CITY]	[STATE] [ZIP CODE]		
YOUTH'S TR	RIBAL INFORMATION		
Please bring Tribal ID (if a	pplicable) to the first appointment.		
Tribal Affiliation: O Native O Non-Native living in	tribal household		
Name of Tribe(s) (if applicable):			
Enrollment Status: O Enrolled (ENROLL. #) O Enrollment Pending O Not Enrolled O N/A		
PARENT/LEGAL G	UARDIAN INFORMATION		
Please bring legal guardian	<mark>'s photo ID to the first appointment.</mark>		
BIOLOGICAL PARENT(S) Name(s):			
Does anyone other than a biological parent have legal	custody? O Yes O No		
If yes , complete legal guardian information below.			
LEGAL GUARDIAN Name:			
Relationship to youth:			
Phone #: () -	Phone Type: O Home O Cell O Work		
INSURANCE ANI	D BILLING INFORMATION		
Please bring insurance	card(s) to the first appointment.		
GUARANTOR (Parent/Guardian responsible for receiving	ng billing statements)		
Name:			
Date of Birth: / /	SSN:		
INSURANCE Insurance Company Name:			
Insurance Member ID:	Subscriber Name:		
APPOINTMENT	CONTACT INFORMATION		
Name:			
Relationship to youth (check all that apply):	Self Parent/Guardian Placement/Foster Parent Other		
Phone #: () -	Phone Type: O Home O Cell O Work		
	ied on next page		
	E. Fam 200 740 0751		
CYF Request for Services – 12/17/18 Please return to CY	<mark>F - Fax: 360-716-0751 1</mark>		

In person: 4033 76th PL NW Tulalip, WA 98271

CURRENT LEGAL DOCUMENTATION					
Please provide a copy of the legal document (if applicable) when submitting this Request for Services.					
Do any of the following apply to the yo	outh? (check all that apply)				
Family Court/Parenting Plan Letters of Guardianship Power of Attorney	Less Restrictive Alternative (LRA) or Conditional release (CR) Under department of corrections (DOC) supervision Under civil or criminal court ordered mental health or				
Advanced Directives for Psychiatric Care Medical and Education Authorization Ord Protection Order	chemical dependency treatment der				
	EDUCATION				
Please provide a copy of the youth's Ind	lividualized Education Plan (IEP) or 504 Plan (if applicable) to the first appointment.				
Current School Name (where enrolled)					
Current Grade Level:					
	BEHAVIORAL HEALTH INFORMATION				
Current mental health diagnosis (if kno					
Currently taking any prescribed psychia	•				
	tric medications to the first appointment.				
Reason for requesting mental health se					
SYMPTOMS OR AREAS THAT MAY BE C	DE CONCERN? (check all that apply)				
	Explanation/Comments:				
Homicidal thoughts or behaviors					
Self-harming behaviors					
Aggressive/violent behaviors					
Impulsive behaviors					
Hallucinations					
Sleep concerns					
Appetite concerns					
Past or present alcohol/drug use					
School, work, etc. concerns					
Other					
If you are in emergent crisis and need to talk to someone now Family Services reception at 360-716-4400 (during normal operating hours), or the Volunteers of America 24 Hour Crisis Line at 1-800-584-3578.					
CLEAR FORM PRINT					

FOR OFFICE USE ONLY							
Request Received	Date:	Staff Initials:	Therapist Assigned	Date:	Staff Initials:		
Transcribed into Epic	Date:	Staff Initials:		Therapist Name:			
Scanned into Epic	Date:	Staff Initials:					