CHILD, YOUTH, AND FAMILY MENTAL WELLNESS

TULALIP HEALTH SYSTEM

BEHAVIORAL HEALTH & RECOVERY

CYF
4033 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

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 INDIVIDUAL COMPLETING REQUEST (Other than legal guardian)

Name: | **Relationship to youth:**

Phone #: ( ) - | **Phone Type:** ○ Home ○ Cell ○ Work

YOUTH INFORMATION

Full Legal Name: [FIRST] [MIDDLE] [LAST]

Nickname (if applicable): | **Date of Birth:** / / | **Age:**

Gender: ○ Male ○ Female ○ Transgender ○ Other _____

Interpreter needed? ○ Yes ○ No | **If yes, language:**

Youth's Address: [STREET]

[CITY] [STATE] [ZIP CODE]

YOUTH'S TRIBAL INFORMATION

Please bring Tribal ID (if applicable) to the first appointment.

Tribal Affiliation: ○ Native ○ Non-Native living in tribal household

Name of Tribe(s) (if applicable):

Enrollment Status: ○ Enrolled (ENROLL.) ○ Enrollment Pending ○ Not Enrolled ○ N/A

PARENT/LEGAL GUARDIAN INFORMATION

Please bring legal guardian's photo ID to the first appointment.

BIOLOGICAL PARENT(S) | **Name(s):**

Does anyone other than a biological parent have legal custody? ○ Yes ○ No

If ***yes***, complete ***legal guardian*** information below.

LEGAL GUARDIAN | **Name:**

Relationship to youth:

Phone #: ( ) - | **Phone Type:** ○ Home ○ Cell ○ Work

INSURANCE AND BILLING INFORMATION

Please bring insurance card(s) to the first appointment.

GUARANTOR (Parent/Guardian responsible for receiving 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:** ○ Home ○ Cell ○ Work

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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 youth? (check all that apply)

- ☐ Family Court/Parenting Plan
- ☐ Letters of Guardianship
- ☐ Power of Attorney
- ☐ Advanced Directives for Psychiatric Care
- ☐ Medical and Education Authorization Order
- ☐ Protection Order
- ☐ Less Restrictive Alternative (LRA) or Conditional release (CR)
- ☐ Under department of corrections (DOC) supervision
- ☐ Under civil or criminal court ordered mental health or chemical dependency treatment
- ☐ Placement Letter
- ☐ Other _____

EDUCATION

Please provide a copy of the youth's Individualized 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 known)?

Currently taking any prescribed psychiatric medications? ○ Yes ○ No

If yes, please bring a list of your psychiatric medications to the first appointment.

Reason for requesting mental health services?

SYMPTOMS OR AREAS THAT MAY BE OF CONCERN? (check all that apply)

- ☐ Suicidal thoughts or behaviors
- ☐ 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 _____

Explanation/Comments:

If you are in emergent crisis and need to talk to someone now, please call the Tulalip Crisis Response Team (CRT) at 360-502-3365, or the Snohomish County Care 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:			