Lutheran Community Services NORTHWEST
Health • Justice • Hope

Children's Intensive Services

REFERRAL FORM **Date:**

NAME OF YOUTH:	DATE OF BIRTH:
ADDRESS:	SEX: ETHNICITY:
CITY, STATE, ZIP:	PROVIDER 1#:
PHONE:	**Program requirement – Medicaid enrolled**
PERSON MAKING REFERRAL:	PHONE:
LIST THE AGENCY/TEAM MEMBER(S) WHO MET WITH FAMILY AND AGREE TO REFERRAL:	

PROGRAM REFERRED TO:	WISe ☐	WRAPAROUND ☐

INVOLVED GURARDIANS/CAREGIVERS	
NAME:	NAME:
ADDRESS:	ADDRESS:
CITY, STATE, ZIP	CITY, STATE, ZIP:
PHONE:	PHONE:
LEGAL GUARDIAN(S)	
LEGAL GUARDIAN NAME:	
ADDRESS:	CITY, STATE, ZIP:

STEP-PARENT SIGNIFICANT OTHERS IN YOUTH'S LIFE

NAME(S)	RELATION	PHONE/ADDRESS

SIBLINGS

NAME(S)	AGE	WHERE LIVING

STRENGTHS/INTERESTS/RESOURCES OF YOUTH AND FAMILY

CURRENT NEEDS/CONCERNS OF YOUTH AND FAMILY

LEGAL ISSUES REGARDING YOUTH

EDUCATION STATUS OF YOUTH	CURRENT IEP?
	YES NO
SCHOOL:	DATE:
SCHOOL CONCERNS:	
DIAGNOSIS INCLUDING DSM IV CODE:	
I:	II:
III:	IV: V:

CURRENT MEDICATIONS	***FREQUENCY/DOSAGE***	***COMPLIANCE***
1.		
2.		
3.		
4.		
5.		

PAST SERVICES RECEIVED: ***INCLUDE ANY RELEVANT DOCUMENTATION INCLUDING PROGRESS SUMMARIES OR TERM SUMMARIES (EXAMPLES MIGHT BE FRS, FPS, YOUTH AT RISK, HOSPITALIZATION, ETC.***

OUT OF HOME PLACEMENTS:	
DESCRIPTION:	DATE:

ADDITIONAL COMMENTS REGARDING YOUTH AND FAMILY:

Please fax completed form to (509) 783-2089
Attn: Sharon Gentry, Program Director

Questions? Please contact Sharon Gentry at (509) 783-2085

Lutheran Community Services - Children's Intensive Services
3321 W KENNEWICK AVE, SUITE 150
KENNEWICK WA 99336