Benton County Behavioral Health--Children's Outpatient Referral

Fax to 541-766-6186

Client Information:

Legal Name: Goes By: Date of Referral:

Address: City: Phone #: Msg Ok? ☐YES ☐NO

Date of Birth: Age: Gender: Pronouns:

School: Grade:

Insurance Info:

☐Oregon Health Plan (*ID #*:) ☐No Current Insurance

☐Private Ins. (*Provider:* *Group:* *ID:*)

Guardian Information:

Guardian 1 (Primary Contact): Relationship: Lives w/ Client? ☐YES ☐NO

Cell Phone: Msg Ok? ☐YES ☐NO Alt. Phone: Msg Ok? ☐YES ☐NO

Guardian 2: Relationship: Lives w/ Client? ☐YES ☐NO

Cell Phone #: Msg Ok? ☐YES ☐NO Alt. Phone: Msg Ok? ☐YES ☐NO

Other household members:

Referral Information:

Individual Referring: Relationship: Phone:

Is the client aware of the referral?

☐ Yes. The client is aware and is: ☐ Interested ☐ Unsure ☐ Resistant

☐ No. Client is not aware.

Is the parent/guardian aware of the referral? (children under 14 require guardian consent)

☐ Yes. I have spoken to the parent/legal guardian regarding the above child. A release of information (ROI) has been signed allowing Benton County Behavioral Health Services to make contact regarding services for above child. (Attach completed ROI to this referral.)

☐ No. The child is 14 years or older and has consented for services independently.

☐ **The client has requested that their services remain confidential from their guardian(s) to the best of the ability of the assigned provider.**

Client Needs:

What are the area(s) of concern?

☐ Anxiety ☐ Relationship Issues ☐ Social Skills Deficit ☐ Family Conflict ☐ Depression
☐ Change in Mood ☐ Impulsivity ☐ Emotion Regulation ☐ Decision-Making ☐ Recent Life Change
☐ Self-Esteem ☐ Self-Identity ☐ Self-Harm ☐ Suicidal Concerns ☐ School concerns ☐ Abuse
☐ Housing Instability ☐ Substance Use ☐ Trauma History ☐Legal Concerns ☐ Poor Boundaries
☐ Other: _____

What are the client's strengths/sources of support?

☐ Future goals ☐ Family support ☐ Socially connected ☐ Asks for help ☐ Uses humor
☐ Problem-solving skills ☐ Communicates well ☐ Academic Skills ☐ Expresses Emotions
☐ Other: _____

What supports/agencies/providers are currently in place?

☐ Individual Therapy ☐ Family Therapy ☐ Group Therapy ☐ Skills Training
☐ Psychiatry/Medication Management ☐ Primary Care Provider ☐ Juvenile Department
☐ IEP/504 Plan ☐ Behavior Support (at school) ☐ Speech Services ☐ Wraparound Services
☐ ESD Family Support Liaison ☐ Substance Use Treatment ☐ DHS (*ROI is required, please attach*)
☐ Other: _____

Reason for Referral (brief description)**:**