REFERRAL FORM FOR EARLY CHILDHOOD MENTAL HEALTH ASSESSMENT - WASHINGTON COUNTY

The agencies listed below accept all children who have OHP and/or qualifying children who do not have medical insurance. Please use this referral form for those families. If a child has private medical insurance, the family should call their insurance provider directly for more information. Families can also call the agencies directly to see if they work with the child's insurance.

1. When completed, this form should be faxed to ONE of the providers listed below. Please indicate the provider you have chosen. Because children are only authorized to work with one mental health provider at a time, sending the referral to more than one provider may affect the family's ability to get an authorization for services and/or create confusion for the family in attempting to access services.

☐ **LifeWorks NW** (offices in Tigard, Beaverton and Hillsboro)
Fax: 503.629.8517 – ATTN: Intake Department
Phone: 503.645.9010

☐ **Morrison Child and Family** (offices in Beaverton)
Fax: 503.350.0415 – ATTN: Intake Department
Phone: 503.258.4496

☐ **Western Psychological** (offices in Tigard, Beaverton and Hillsboro)
Tigard Fax: 503.624.7752 Tigard Phone: 503.624.2600
Beaverton Fax: 503.646.8401 Beaverton Phone: 503.626.9494
Hillsboro Fax: 503.531.3841 Hillsboro Phone: 503.439.9531

☐ **Youth Contact** (offices in Beaverton and Hillsboro)
Fax: 503.640.0334
Phone: 503.640.4222

2. Consent of family to be called by the provider indicated above
My signature below indicates that I agree to receive a phone call to schedule an initial appointment for treatment services and to have the information on this form shared with the provider indicated above. This form also authorizes the provider agency to share information about my family with the personnel of ___Head Start – JJJ Elem__________.
(name of referring agency)

Mi firma abajo indica que estoy de acuerdo que una persona me llame para hacer una cita inicial para servicios de tratamiento y que la información en esta forma sea compartida con la agencia indicada arriba. Este formulario autoriza la agencia que va a proveer los servicios a compartir información sobre mi familia con el personal de
____.
(nombre de la agencia que hizo la referencia)

Signature of parent o guardian/Firma del padre de familia o guardián: ________________________________ Date/Fecha: _________________

3. General information about the child/family being referred

Date:	April 26, 2011		
Child's Name:	Dave Smith	Child's DOB:	November 29, 2003
Name of legal guardian and relationship to child:	Mr. and Mrs. Smith - parents	Primary language of family:	English
Insurance carrier and ID number (or uninsured):	OHP – GR100007	Phone number of legal guardian:	503.111.1111

4. Information about the concern (Please include information about concerns at home, at school and in the community.)

Concerns about child's safety:	Runs out into street at home; runs out of classroom at school; hits younger brother with toys; hits peers in classroom
Concerns about parent/guardian-child relationship:	Parents report no concerns School reports that child often says that he wants to stay at school instead of going home because "no one wants to play with me at home"
Concerns about child's caregiving environment (home, school, babysitter, etc.):	Family reports history of DHS involvement School reports poor "fit" between teacher and child
Concerns about child's functional/developmental status:	Child was evaluated by EI for concerns about speech but did not qualify for services Parent reports that child is not as independent in dressing himself as they would have expected
Impact of the above concern(s) on the child and family:	Family reports that they are able to manage child's behavior fine at home – "that's just the way he is" School reports that he is on a behavior plan and that he needs to be sent home about once a week because of aggressive behavior in the classroom

5. Information about the referent

Name of referent:	Maria Lopez	Name of referring agency (if applicable):	Head Start – JJJ Elementary School
Phone number of referent:	503.222.2222	Fax number of referent:	503.333.3333
E-mail of referent:	marialopez@hs.org		

6. Information for Intake Department
Please indicate the hours which are most convenient for the family to receive a call to schedule their appointment.
☐ 9 to 11 am ☐ 11 am to 2 pm ☒ 2 to 5 pm ☐ Any

Does the family consistently receive messages at this phone number? ☐ YES ☒ NO

7. Information about requests for agency follow-up
Provider should send information re: action taken ☒ YES ☐ NO

Intake Department staff will contact referent if no appointment is scheduled.
Clinician will contact referent if they have an ROI signed by the family. This contact will be documented in the client chart.

8. Action taken by provider: ____