

**Lighthouse Youth and Family Services – Referral Form**

**PLEASE RETURN THIS FORM, ALONG WITH ANY SUPPORTING RECORDS/DOCUMENTATION TO OUR INTEGRATED ACCESS TEAM**

Phone: (513)487-6705 Fax: (513)221-1901 Email: IntegratedAccess@lys.org  
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| **Date of Referral:** |  |

**Check Service(s) Referral is being made for: Include the following w/ referral: Insurance Card, any psych evals & prior treatment records, Social Security Card, Birth Certificate, if available.**

Assessment Services  Psychiatric Services

Therapy Services  Assertive Community Treatment (ACT)

Wraparound Services  Substance Use Disorder (SUD)

**Client’s Information:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Legal Name: |  | | | | | |  | |  | | | | | Date of Birth: | |  | | Age: | |  | | | Gender: | |  | | Ethnicity: | | |  | | |
|  | First | | | | | | MI | | Last | | | | |  | | | | | | | | | | | | | | | | | | |
| Social Security Number: | | | |  | | | | Insurance Provider Name: | | | | |  | | | | | | | | | Insurance ID Number: | | | |  | | | | |
| Phone Number: | |  | | | | Check One: | | | | Mobile  Home  Work | | | | | Daytime Number: | | | |  | | | | | Check One: | | Mobile  Home  Work | | | | | | |
| Address (city/state/zip): | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Who has custody/guardianship of the youth? (If Applicable): | | | | | | | | | | |  | | | | | | | | | | Relationship to youth? (If Applicable): | | | | | | |  | | | | |
| Primary Language: | | |  | | | | | Secondary Language: | | | |  | | | | | Is an interpreter needed for services provided in English? | | | | | | | | | | | | Yes  No | | | |
| Emergency Contact (name/address): | | | | |  | | | | | | | | | | | | | | | Relationship: | | |  | | | | | | Emergency Contact Phone: | | |  |

**Referral Information:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Person Making Referral: | |  | | Phone Number: | |  | Fax #: |  | |
| Email Address: |  | | Referring Agency: | |  | | | |

**Reason for Referral/Presenting Problem:**

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**Other Agencies Currently Involved with Client:**

Agency Contact Person Phone Number Email Address Service Provided Service will remain open

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**Family Information (For Youth Only):** **Medical Information:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Guardian(s) Name: | | | |  | | | |  | | | | Current Medication(s) and Dosage: | | | |
| Address: | |  | | | | | | | | |  | 1. |  | |
| Phone # (Cell): | | |  | | Dayime/Work: | |  | |  | | | 2. |  | |
| Additional Guardian’s Name(if applicable): | | | | | |  | | | | |  | 3. |  | |
| Address: | |  | | | | | | | | |  | 4. |  | |
| Phone # (Cell): | | |  | | Dayime/Work: | |  | |  | | | Prescribing Doctor/Psychiatrist: | |  |
| If we are unable to reach a parent/guardian, who can we call to assist us? | | | | | | | | | | |  | Does the client have any medical concerns:  Yes  No (If Yes, Explain Below) | | | |
| Name: |  | | | | | | | Phone: | |  |  |  | | | |
| Relationship to client? (grandparent/aunt/friend, etc.): | | | | | | |  | | | |  |

**Other’s Living in the Client’s Home:** **Current Diagnosis:**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: |  | Relationship to Client: |  | Age: |  |  | Source: |  | | Date: Given: |  |
| Name: |  | Relationship to Client: |  | Age: |  |  | Please List Diagnosis: | |  | | |

**School Information (For Youth Only):**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name of School: | |  | | School District: | |  | |
| Contact Person: | |  | | | Phone: | |  |
| Grade: |  | | Is there a current IEP?  YES  NO | | | | |