

**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:**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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:**

|  |
| --- |
|       |

**Other Agencies Currently Involved with Client:**

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

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|       |  |       |  |       |  |       |  |       |  |  |
|       |  |       |  |       |  |       |  |       |  |  |

**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 |