LIGHTHOUSE YOUTH & FAMILY SERVICES

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: _____ **Include the following w/ referral: Insurance Card, any psych evals & prior treatment records, Social Security Card, Birth Certificate, if available.**

Referral Information:

School Name: _____ Grade: _____ Is there a current IEP? ☐ YES ☐ NO

Person Making Referral: _____ Phone Number: _____ Fax #: _____ Email Address: _____

Contact person if different than person making the referral: _____ Phone: _____

Client's Information:

Legal Name: _____ Date of Birth: _____ Age: _____ Gender: -- select one-- 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: _____

Reason for Referral/Presenting Problem:

(Please be as detailed as possible):

Family Information (For Youth Only):

Guardian(s) Name: _____

Address: _____

Phone # (Cell): _____ Daytime/Work: _____

Additional Guardian's Name(if applicable): _____

Address: _____

Phone # (Cell): _____ Dayime/Work: _____

Medical Information:

Current Medication(s) and Dosage:

1. _____
2. _____
3. _____
4. _____

Prescribing Doctor/Psychiatrist: _____

Current Diagnosis:

Source: _____ Date Given: _____ Please List Diagnosis: _____