

***Children’s Home Society of Washington***

***Counseling Services Referral Form***

***LGBTQ+ Youth***

*When completed, this form is returned to CHSW ATTN:* Luz Estrada, Triple Point Facilitator

Phone: (509) 663-0034 & Fax: (509)663-3726

Date of Referral: Referent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender Identity(examples: cisgender male, transgender female, non-binary, etc.):

Child’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Language Spoken by Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By Parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_IEP/504

Systems Involved In:

\_\_ Juvenile Justice \_\_ Counseling/Therapy \_\_ Substance Abuse \_\_ Special Education

\_\_ Crisis Services \_\_ Division of Youth and Family Services/Child Protective Services \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Behavioral Concerns:

\_\_ Opposition/Conduct \_\_ Mood Disorder \_\_ Adjustment to Trauma \_\_Anxiety

\_\_ Attention/Impulse \_\_ Substance Abuse \_\_ Emotional Control \_\_ Psychosis

Mental Health related ER visits (include date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Inpatient Hospitalizations (include date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly Describe Reason for Referral:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| CHSW Staff: Assessment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client/Family Response: \_\_\_Decline \_\_\_Accept Referral Notified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Last reviewed 11/20**  |