Linn County Mental Health New Solutions Referral

Referral Date: _____

Referral for:

- ☐ Wraparound **(OHP, Kaiser Permanente or Pacific Source insurance required)**

Youth Name: _____ **DOB:** _____ **Age:** _____

Gender: _____ **Gender Identity:** _____ **Pronouns:** _____

Oregon Health Plan: ____ Yes ____ NO OHP Member ID: _____

Does the youth have private insurance in addition to OHP? ____ Yes ____ NO

If yes, private insurance carrier: _____

Referred By: _____ Relationship: _____

Phone/Email: _____

Please mark things that pertain to youth:

- ☐ Mental health acuity exhibited by high-risk behavior
- ☐ At risk of placement disruptions or have had placement disruptions within the past year
- ☐ Being served by 2 or more child serving agencies
- ☐ Behaviors are impacting the youth's ability to receive appropriate education
- ☐ Other interventions have been tried without sustained success

Please mark all the systems the youth and their family are involved in

- ☐ Mental Health
- ☐ Intellectual or Developmental Disabilities service coordinator
- ☐ Juvenile Justice Probation Officer/OYA/In detention
- ☐ Department of Human Services Permanency Worker
- ☐ Alcohol and Drug Services
- ☐ Jackson Street Youth Services Case Manager
- ☐ Individualized Education Plan

Please mark supports previously attempted

- ☐ Skills training
- ☐ Intensive outpatient (weekly therapy and skills training)
- ☐ Medication Management
- ☐ Collaborative Problem-Solving Classes
- ☐ Day treatment
- ☐ Residential Treatment

Contact Information

Guardian(s): _____

Address: _____

Phone/Email: _____

Youth Currently Lives with: _____

Phone/Email: _____

Current School: _____ Grade: _____

Teacher/staff: _____

Phone/Email: _____

Current Mental Health Provider: _____

Phone/Email: _____

ODHS Child Welfare Worker: _____

Phone/Email: _____

Jackson Street Contact: _____

Phone/Email: _____

Developmental Disabilities Service Coordinator: _____

Phone/Email: _____

Juvenile Probation Officer: _____

Phone/Email: _____

Alcohol & Drug Counseling: _____

Phone/Email: _____

Guardian Signature: _____ **Date:** _____

Demographic Form

Gender Identity

☐ Female ☐ Male ☐ Non-Binary
☐ Other-Specify_____ ☐ Prefer not to say

Transgender?

☐ Yes ☐ No ☐ Questioning

Sexual Orientation

☐ Asexual ☐ Bisexual ☐ Gay ☐ Heterosexual/Straight
☐ Lesbian ☐ Pansexual ☐ Queer ☐ Questioning
☐ Other-Specify_____ ☐ Prefer not to answer

Race

☐ White ☐ Black/African American ☐ Native American/Alaska Native
☐ Asian ☐ Hawaiian/Pacific Islander ☐ Other-Specify_____
☐ Multi-Racial-Specify_____
☐ Prefer not to say

Ethnicity

☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Reason for referral

Describe the youth and family strengths:

Describe the identified needs:

Cultural Considerations:

Any other services:

*****FAX Referral Packet to: Linn County Mental Health New Solutions @ (541) 812-8807*****