Outpatient Referral Form

Submit completed referral form to KCOutpatient@senecacenter.org
Call 206-490-0865 for more info

Date of Referral:	**Office Only**	
Name of Referent:	INTAKE APPT DATE & TIME:	
Referent Phone No.:	THERAPIST ASSIGNED:	
Referent Email:	SCHEDULED BY:	
Relationship to Client:	SCHEDULED ON:	
CLIENT INFORMATON		
Name:	DOB:	Age:
Ethnicity:	Primary Language:	
Gender:	Pronouns:	
Child/Youth Primary Address:		
Child/Youth Phone:	Voicemails ok? Yes ☐ No ☐	
Primary Caregiver(s) Name/Relationship to Youth:		
Phone:	Voicemails ok? Yes ☐ No☐	
Email:		
Do you have primary insurance? Yes ☐ No ☐		
Primary Insurance:	Policy/Member Number:	
Other Important Adults/Family Member(s)		
Name:	Relationship to Child/Youth:	
Name:	Relationship to Child/Youth:	

REASON FOR REFERRAL

Presenting Symptoms (please circle all that apply):

Suicidal Ideation ☐	Depressed Mood ☐	Tearful/Cries Often ☐	Hyperactive ☐
Suicide Attempt ☐	Social Withdrawal ☐	Easily Distracted ☐	Poor Impulse Control ☐
Physical Aggression ☐	Verbal Aggression ☐	Anxious ☐	Fidgety ☐
Paranoia ☐	Hypervigilant ☐	Obsessive Thoughts ☐	Compulsive Behavior ☐
Self-Mutilation ☐	Phobias ☐	Bedwetting ☐	Nightmares ☐
Hallucinations ☐	Disrupted Sleep ☐	Harmful to animals ☐	Drug Use ☐
Homicidal Ideation ☐	Weight loss/gain ☐	Poor social skills ☐	Disrupted Attachment ☐

Reasons for Referral to Therapy:

Previous behavioral/mental health treatment? No ☐ Yes ☐

CONTACT (Check all that apply)

Best days to contact: M ☐ T ☐ W ☐ Th ☐ F ☐	Time of day: Mornings ☐ Afternoons ☐ Evening ☐

INTAKE AVAILABILITY (Check all that apply)

Best days for meeting: M ☐ T ☐ W ☐ Th ☐ F ☐	Time of day: Mornings ☐ Afternoons ☐ Evening ☐

OFFICE ONLY	
Client has active Medicaid with qualifying benefits plan: Yes ☐ No ☐	Eligibility check completed on:
Is client receiving MH services with another agency? Yes ☐ No ☐	
Notes:	

CLIENT CONTACT & INTAKE TACKER (OFFICE ONLY)				
Date of Contact:	Staff Reaching Out:	Intake Date Offered:	Accept ☐ Decline ☐	If Decline, reason why:
Date of Contact:	Staff Reaching Out:	Intake Date Offered:	Accept ☐ Decline ☐	If Decline, reason why:
Date of Contact:	Staff Reaching Out:	Intake Date Offered:	Accept ☐ Decline ☐	If Decline, reason why:
Date of Contact:	Staff Reaching Out:	Intake Date Offered:	Accept ☐ Decline ☐	If Decline, reason why:
Notes:				
When the referral is completed please pass on to assigned therapist, HIS & Program Supervisor				