



King County WISe Referral Form

Call us at (206) 490-0985 and we can fill out the referral form with you or send a completed form to our secure fax: 510-830-3596

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 INFORMATION			
Name:	DOB:	Age:	
Ethnicity:	Primary Language:		
Gender:	Pronouns:		
Child/Youth Primary Address:			
Child/Youth Phone:	Voicemails ok? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Primary Caregiver(s) Name/Relationship to Youth:			
Phone:	Voicemails ok? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Email:			
Do you have primary insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>			
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 <input type="checkbox"/> Yes <input type="checkbox"/>			
CONTACT (Check all that apply)			
Best days to contact: M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/>	Time of day: Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Evening <input type="checkbox"/>		
INTAKE AVAILABILITY (Check all that apply)			
Best days for meeting: M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/>	Time of day: Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Evening <input type="checkbox"/>		
Interest in which Seneca Services:	Outpatient Services <input type="checkbox"/>		WISe Services <input type="checkbox"/>



OFFICE ONLY	
Client has active Medicaid with qualifying benefits plan: Yes <input type="checkbox"/> No <input type="checkbox"/>	Eligibility check completed on:
Is client receiving MH services with another agency? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Notes:	

CLIENT CONTACT & INTAKE TRACKER (OFFICE ONLY)				
Date of Contact:	Staff Reaching Out:	Intake Date Offered:	Accept <input type="checkbox"/> Decline <input type="checkbox"/>	If Decline, reason why:
Date of Contact:	Staff Reaching Out:	Intake Date Offered:	Accept <input type="checkbox"/> Decline <input type="checkbox"/>	If Decline, reason why:
Date of Contact:	Staff Reaching Out:	Intake Date Offered:	Accept <input type="checkbox"/> Decline <input type="checkbox"/>	If Decline, reason why:
WISe Only: Initial CANS screening done? Yes <input type="checkbox"/> No <input type="checkbox"/>			Date completed:	
Notes:				