OUTPATIENT MENTAL HEALTH

For local young people and families impacted by trauma, anxiety, depression and other profound challenges, Seneca's Outpatient Clinic offers individual and family therapy, intensive social-emotional support and crisis services, and psychiatry services.

Who is eligible for services?
Children and youth ages 5-18 who are King County Medicaid eligible

What are Seneca's service areas?
Primarily South King County, including South Seattle, West Seattle, White Center, Burien, Tukwila, SeaTac, Renton and Des Moines

Clinic Location
13925 Interurban Ave S
Suite 120
Tukwila, WA 98168

Referrals/Contact
Main: 206-948-0096
***Toll-Free:* 833-522-0137.**
KCOutpatient@senecacenter.org

www.senecafoa.org

SENECA
FAMILY OF AGENCIES | UNCONDITIONAL CARE

Outpatient Referral Form

Call our main line 206-948-0096 or toll-free line 833-522-0137;

Email: KCOutpatient@senecacenter.org or send via confidential 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? Yes ☐ No ☐	
Primary Caregiver(s) Name/Relationship to Youth:		
Phone:	Voicemails? Yes ☐ No☐	
Email:	Primary Caregiver Language:	
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:	
School:	Preferred location: Clinic School Virtual	

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 ☐

<table>
<tr><th colspan="2">OFFICE ONLY</th></tr>
<tr><td>Client has active Medicaid with qualifying benefits plan: Yes ☐ No ☐</td><td>Eligibility check completed on:</td></tr>
<tr><td colspan="2">Is client receiving MH services with another agency? (King County Only) Yes ☐ No ☐</td></tr>
<tr><td colspan="2">Notes:</td></tr>
</table>

<table>
<tr><th colspan="5">CLIENT CONTACT & INTAKE TACKER
(OFFICE ONLY)</th></tr>
<tr><td>Date of Contact:</td><td>Staff Reaching Out:</td><td>Intake Date Offered:</td><td>Accept ☐ Decline ☐</td><td>If Decline, reason why:</td></tr>
<tr><td>Date of Contact:</td><td>Staff Reaching Out:</td><td>Intake Date Offered:</td><td>Accept ☐ Decline ☐</td><td>If Decline, reason why:</td></tr>
<tr><td>Date of Contact:</td><td>Staff Reaching Out:</td><td>Intake Date Offered:</td><td>Accept ☐ Decline ☐</td><td>If Decline, reason why:</td></tr>
<tr><td>Date of Contact:</td><td>Staff Reaching Out:</td><td>Intake Date Offered:</td><td>Accept ☐ Decline ☐</td><td>If Decline, reason why:</td></tr>
<tr><td colspan="5">Notes:</td></tr>
<tr><td colspan="5">When the referral is completed please pass on to assigned therapist, HIS & Program Supervisor</td></tr>
</table>