Cowlitz Tribal Health Seattle
15455 65th AVE SOUTH TUKWILA, WA 98188
MAIN: 206.721.5170 FAX: 206.721.6288

REFERRAL FOR COUNSELING SERVICES-ADULT

Please fill this form out as completely as possible

DATE:_____NAME:_____DOB:_____
Identifies as: ☐Female ☐Male ☐Transgender ☐Two-Spirit ☐Prefer not to share

ADDRESS: _____ CITY/STATE:_____ ZIP: _____

HOME PHONE:_____ OTHER PHONE: _____ CAN WE LEAVE MSG: YES/NO

EMAIL ADDRESS: _____@_____ CAN WE TEXT YOU? YES/NO

TRIBAL AFFILIATION: _____ ENROLLED or a DESCENDENT? _____

Can you provide documentation? (Tribal ID, BIA Cert, Etc) _____

Please provide tribal affiliation documentation (BIA Certs, Tribal ID, Cert of Indian Blood, Etc.) along with this referral form.

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PRIMARY INSURANCE INFORMATION: ***(Please provide copy of front/back of Insurance Card(s)***
Primary Insurance Company Name: _____
Policy Holder Name: _____ Policy Holder Birth date: _____
Employer: _____ ID# _____ GROUP #_____
Relationship to Policy Holder: _____Phone # on back of Card: _____

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REASON FOR REFERRAL:

_____

Are you currently having thoughts of hurting yourself or someone else? ☐ Yes ☐ No
Do you currently have a plan to hurt yourself or someone else? ☐ Yes ☐ No
Have you had recent contact (within 1 month) with any emergency department for mental health concerns?
☐ Yes If yes, where?_____ ☐ No
Are you court-ordered to participate in mental health services?
☐ Yes If yes, by who? _____ ☐ No
Are you currently receiving mental health services or medication from another agency?
☐ Yes If yes, where? _____☐ No

What services are you seeking from us? (Check all that apply)
☐ Individual counseling ☐Family counseling ☐Group Therapy ☐Chemical Dependency ☐Pathways to Healing (DV/SA) ☐MAT -Medicine Assisted Treatment (Suboxone/Vivitrol/Narcan Kit/Fentanyl strips) PARENT SUPPORT (Strive)

PREFERENCES: **(we cannot always accommodate all preferences for service request)**
The following days work best for me to meet:
☐ M ☐T ☐W ☐Th ☐F
I prefer : ☐ 8a-12p ☐ 12p-3p ☐ 3p-5p
I prefer :☐ in-home services ☐ in-office services (Tuk or DP)
I prefer : ☐ a female therapist ☐ a male therapist
☐ no preference

PERSON REFERRING:_____ Phone: _____
RELATIONSHIP TO CLIENT:_____ EMAIL: _____
How did you hear about us? _____
SIGNATURE: _____DATE_____
(If verbal approval please specify)

Telehealth? (please circle)
Yes NO

Form Completed By:_____ (IN OFFICE USE ONLY)