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

REFERRAL FOR COUNSELING SERVICES-STUDENT

Please fill this form out as completely as possible

STUDENT:_____ Date:_____GRADE:_____ DOB:_____

Student identifies as: ☐ Female ☐ Male ☐ Transgender ☐ Two-spirit ☐ Prefers not to share

**If the student is over the age of 13, do we have permission to contact parent/guardian? ☐ Yes ☐ No

SCHOOL:_____ PARENT/GUARDIAN NAME:_____

ADDRESS: _____City/State: _____ Zip:_____

HOME PHONE:_____ OTHER PHONE: _____

EMAIL ADDRESS: _____@_____

TRIBAL AFFILIATION: _____ IS STUDENT 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 Student: _____Phone # on back of Card: _____

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REASON FOR REFERRAL: (LIST AREAS OF CONCERN)_____

Please Answer the Following	What services are you seeking from us? (check all that apply)
Does this student have thoughts of suicide? ☐Yes ■ No	☐Individual counseling ☐Family counseling
A plan to hurt themselves/someone else? ☐ Yes ■ No	☐Group Therapy ☐Chemical Dependency ☐Pathways to Healing
Received emergency mental health is the past month? ☐Yes ☐No If Yes, where?_____	PREFERENCES (Note: we cannot always accommodate all preferences for service request) (please select one)
Currently receive mental health or medications at another agency? ☐Yes ☐No If yes where?_____	☐Student can go to the office for services: ☐Tukwila ☐DuPont
Are mental health services court-ordered? ☐Yes ■ No	Student prefers services: ☐ at school ☐ at home
If yes by who:	Student prefers: ☐ 8a-12p ☐ 12p-3p ☐ 3p-5p
	Student prefers: ☐female ☐male therapist ☐no preference

PERSON REFERRING:_____ Phone: _____

RELATIONSHIP TO STUDENT:_____

EMAIL ADDRESS: _____@_____

How did you hear about us? _____

Telehealth? (please circle)

Yes No

I have received permission from parent/guardian to submit this referral (Check one) ☐ Yes ☐ No