



## Services for Children & Adolescents with Intensive Mental Health Needs

# REFERRAL FORM

Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

IF CHILD IS COVERED BY OREGON HEALTH PLAN: Identification # from medical card \_\_\_\_\_

IF CHILD IS COVERED BY OTHER INSURANCE: Insurance company name \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Phone \_\_\_\_\_

Referent Name \_\_\_\_\_ Organization \_\_\_\_\_ Phone \_\_\_\_\_

### **These are the steps in determining need for intensive mental health services:**

1. Anyone involved with the child **calls OR sends this referral form to the New Solutions** staff in the county where the child resides (address, phone and fax numbers listed below). The parent/guardian will receive a call regarding your referral within 3 working days.
2. A New Solutions staff member meets with parent/guardian to get signed consent for screening, permission to collect the information listed below, and to provide information about New Solutions, confidentiality protections and complaints rights.
3. New Solutions staff obtains a mental health assessment of the child, written or updated within the last sixty days. If such a report is not available, arrangements are made to obtain a mental health assessment.
4. New Solutions staff makes phone contact with the persons identified by the parents who are familiar with the child's situation and can contribute to assessing the child's needs.
5. Within 3 working days of obtaining the information listed above, the *Child and Adolescent Service Intensity Instrument* (CASII) is completed and reviewed with the other information to determine what level of services the child needs.
6. A **New Solutions** staff member contacts (by phone and letter) the parent/guardian to inform them of the results of the screening and to begin connecting them with appropriate services.

***I consent to the referral of my child to be screened for intensive mental health services.***

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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