Cowlitz Tribal Health Seattle

15455 65th AVE SOUTH TUKWILA, WA 98188
BEHAVIORAL HEALTH MAIN: 206.721.5170 BH FAX: 206.721.6288
CHEMICAL DEPENDENCY MAIN: 206.466.5112 CD FAX: 206.453.4404

REFERRAL FOR COUNSELING SERVICES

Please fill this form out as completely as possible to ensure we can provide each client with the best services and assignments possible!

DATE:__________________ **Circle One:** Male/Female

STUDENT:____ GRADE:________ DOB:_______________________

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:
Primary Insurance Company Name: ____
Policy Holder Name: _________________________________ Policy Holder Birth date: ________________________
ID# _______________________________ Phone # on back of Card: ____

....

PERSON REFERRING:_________________________________ Phone: ________________________

RELATIONSHIP TO STUDENT:____

EMAIL ADDRESS: ____@___________________

REASON FOR REFERRAL: (LIST AREAS OF CONCERN)

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____
____
____
____

What services are you seeking from us? (check all that apply)

☐ Individual counseling ☐ Family counseling ☐ Group Therapy ☐ Chemical Dependency

☐ Other____

How did you hear about us? ____

PARENT/GUARDIAN SIGNATURE: ____DATE____________

(If verbal approval please specify)