North Sound BH-ASO
2021 E. College Way, Suite 101, Mt. Vernon, WA 98273
Phone: (360) 416-7013 Fax: (360) 899-4754
www.nsbhaso.org

Youth Navigator Referral Form

Please complete the form. We will respond to you as quickly as possible.

Who is filling out this form

First Name:

Last Name:

Phone Number:

Do you prefer Email/Text/Phone call? Select Option

May we Leave Sensitive Information? Select Option

Best time to reach you:

Email:

Relationship to youth (Check all that apply):

Legal Guardian/Caregiver ☐
Crisis Response Staff ☐
WISe Provider ☐
School Personnel ☐
Other:

Therapist ☐
Medical Personnel ☐
Hospital Staff ☐

First Name of Youth:

Last Name of Youth:

Youth Age:

Youth Date of Birth:

Youth Address:

Youth Address (line 2):

Youth City:

Youth State: Select Option

Zip Code:

Legal Guardian notified of referral: Select Option

Legal Guardian First Name:

Legal Guardian Last Name:

Legal Guardian Phone Number:

Legal Guardian Email:

Release of information ROI completed Select Option

Continued Information about Youth

Race/Ethnicity: Select Option

Gender: Select Option

Tribal Affiliation: Select Option

Preferred Language: Select Option

Enter language if other is selected:

Interpreter Needed: Select Option

County of Residence: Select Option

Enter only if other selected:

Insurance: Select Option

Enter only if other selected:

Primary Care Physician (PCP): Select Option

Mental Health Counselor: Select Option

Youth Currently at Emergency Department? Select Option

Is Youth Involved with Special Education? Select Option

Home School District:

Home School Representative:

Home School Name:

Treatment Interventions (Current and Historical)
(Check all that apply)

Psychiatric Hospitalizations ☐
Residential Treatment ☐
Partial Hospital Program (PHP) ☐
Wraparound with Intensive Services (WISe) ☐
Other:

Outpatient ☐
CLIP Admission ☐
ER Visit for Behavioral Health ☐
Intensive Outpatient Program (IOP) ☐

Strengths/Interests (2,000 character limit)

Presenting Symptoms:
(Check all that apply)

Physical Aggression ☐
Threatening Behaviors ☐
Anxiety ☐
Inappropriate Sexual Behaviors ☐
Self-Harm Behaviors ☐
School Attendance Non-Compliance ☐
Treatment Non-Compliance ☐
Homicidal Thoughts/Gestures ☐
Abuse/Neglect ☐
Other:

Medication Non-Compliance ☐
Auditory/Visual Hallucinations ☐
Suicidal Thoughts/Attempts ☐
Verbal Aggression ☐
Impulsivity ☐
Depression ☐
Run Away/Elopement ☐
Trauma ☐
Drug/Alcohol Concerns ☐

What is the current concern? (2,000 character limit)

Desired outcomes of referral? (1,400 Character limit)

Developmental Disability Involved? Select Option

Involved in the Legal System? Select Option

Department of Children Youth & Families (DCYF) Involvement? Select Option

If Yes, Enter DCYF Name:

If Yes, Enter DCYF phone number:

Natural Support Systems (800 character limit):

By checking here, you are requesting a copy of this referral ☐

By checking here, I attest that I have read and agreed with the North Sound BH-ASO **Privacy Policy** ☐