NORTH SOUND BEHAVIORAL HEALTH
ADMINISTRATIVE SERVICES
ORGANIZATION

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www.nsbhaso.org

Youth Navigator Referral Form

Please complete this from. 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

Best time to reach you:

Email:

Relationship to youth (Check all that apply):

Legal Guardian/ Caregiver ☐ Therapist ☐

Crisis Response Staff ☐ Medical Personnel ☐

WISe Provider ☐ Hospital Staff ☐

Other:

Please attest that you have notified the family and or youth of this referral ☐

Youth's Information

First name of youth:

Last name of youth:

Youth age:

Youth Date of Birth:

Gender: Select Option

Youth State: Select Option

Youth City:

Zip Code:

Preferred Language: Select Option

Interpreter Needed: Select Option

Enter language if other is selected:

Insurance: Select Option

Enter only if other is selected:

Caregiver Information

Caregiver First Name:

Caregiver Last Name:

Caregiver Phone Number:

Caregiver Email:

I am able to make Health Care Decision for this youth ☐

Youth Currently at Emergency Department? Select Option

Presenting Symptoms
(check all that apply)

Physical Aggression ☐

Threating Behaviors ☐

Anxiety ☐

Inappropriate Sexual Behaviors ☐

Impulsivity ☐

Medication Non-Compliance ☐

Auditory/ Visual Hallucinations ☐

Suicidal Thoughts/ Attempts ☐

Verbal Aggression ☐

Self- Harm Behaviors ☐

School Attendance Non-Compliance ☐

Depression ☐

Treatment Non-Compliance ☐

Run Away/ Elopement ☐

Homicidal Thought/ Gestures ☐

Trauma ☐

Drug/ Alcohol Concerns ☐

Abuse/ Neglect ☐

Other:

What is the Current Concern?

Desired outcomes of referral?

Any other information you feel is important for this referral:

Email Referrer a Secure Copy of this Referral? ☐

By Checking here, I attest that I have read and agreed with the BH-ASO Privacy Policy ☐