# MENTAL HEALTH REFERRAL FORM
# RENTON AREA YOUTH & FAMILY SERVICES

***Please FAX to RAYS Office at: 425-227-8926***

Date:____________

Referring provider/staff:_______________________________________Phone#:_____________________

Youth Name:_______________________________________________________DOB:______________

Parent Name:______________________________________________ Phone #:____________________

Grade:__________________ School:_________________________________________________

**Have you spoken to the Youth and/or guardian about the referral to RAYS?** YES NO

**Remember that in order for RAYS to contact legal guardians of the child being referred, the referring program or school needs to make initial contact to get permission from the legal guardian.*

Youth also referred to:

- ❑ Drug/Alcohol counselor
- ❑ Communities in schools – liaison
- ❑ School Counselor_______________
- ❑ School Psychologist_____________
- ❑ Other_________________________

Type of services requested:

- ❑ Individual/family
- ❑ Therapeutic group

Insurance / Payment information – if known

- ❑ Medicaid #________________
- ❑ Other:____________________

Summary of issues/concerns:

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We will do our best to serve this child. If we are unable to serve this child due to funding issues or unavailability, we will make a referral to another provider or agency.

**FOR RAYS CLINICIAN USE ONLY:**

**Request for service date:** ________________________ **Intake offered date:** ______________________________