

SPOKANE TRIBE OF INDIANS
Behavior Health
P.O. Box 540
Wellpinit, WA 99040
(509) 258-7502

REFERRAL FOR SERVICES

DATE: _____ REFERRED BY: _____ Phone: _____

ADOLESCENT 7-15 () _____ CHILD 1-6 () _____

NAME: _____ DOB: _____

ADDRESS: _____

PHONE: _____ Do you have Medicaid _____ Tribe Enrolled: _____

REASON FOR REFERRAL: (Must have supporting documentation/observation)

Mental Health ()

Substance Abuse ()

Court Ordered () Order Attached?

LIST PROBLEMS IDENTIFIED:

Present Situation:

APPROPRIATE RELEASES SIGNED BY CLIENT? Y () N ()

School is asking for a release? Y () N ()

Referent _____ MH Counselor _____ CD Counselor _____

Please turn referral into Behavioral Health Office Manager. This referral will be staffed and assigned to a counselor during clinical staffing after all supporting documents are provided. Kim Norman fax 258-4480.

