



Community Integrated Health Services

School-Based Services | Lewis

Mental Health Referral Form

Please Select a School District:

Centralia **Chehalis** **Napavine**

Referring Party Information	
Date of Referral:	Outside Agency:
Referring School Name:	
<input type="checkbox"/> Early Childhood Education <input type="checkbox"/> Elementary School <input type="checkbox"/> Middle School <input type="checkbox"/> High School	
Name of Person Referring:	Title:
Student Information	
Last Name:	First Name:
Date of Birth:	Grade:
Home Phone:	Cell Phone:
Email:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Intersex <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Unknown
Communication Preference: <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Text <input type="checkbox"/> Email	
Street Address:	City:
State:	Zip:
If the student is 13 years of age or older, they can legally consent to behavioral health treatment on their own. If the student does not wish to have Medicaid insurance statements or other treatment-related correspondence sent to the above mailing address, if known, please mark this box: <input type="checkbox"/>	
If the student is 13 years of age or older; does the student want their parent/guardian to have knowledge of the referral?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Parent/Guardian Information	
Parent/Guardian Full Name:	Parent/Guardian Phone #:
Relationship (please indicate if custodial parent, legal guardian, etc.):	
Parent/Guardian Full Name:	Parent/Guardian Phone #:
Relationship (please indicate if custodial parent, legal guardian, etc.):	
Reason for Referral	
Briefly tell us why you feel this child would benefit from our services:	
<hr style="border-top: 1px dotted #000;"/> <hr style="border-top: 1px dotted #000;"/> <hr style="border-top: 1px dotted #000;"/> <hr style="border-top: 1px dotted #000;"/> <hr style="border-top: 1px dotted #000;"/>	
If the parent/guardian has been contacted and are waiting for CIHS to call and schedule an intake, please mark this box: <input type="checkbox"/>	

Community Integrated Health Services (CIHS)
Lewis County Mailing Address: P.O. Box 579, Centralia, WA 98531
Phone: (360) 261-6930 or (855) 303-4834 | **Fax:** (360) 748-4480 or (844) 554-3370
Website: www.cihealthservices.com

For Office Use Only	
Medicaid/Insurance Status & P1 Number:	
Student is Under 13 Years of Age: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Affiliated with Other Agency: <input type="checkbox"/> Yes, Agency: <input type="checkbox"/> No	
First Intake Date Offered:	Intake Date Accepted:
Intake Completion Date:	First Session Date: