Community Integrated Health Services

Youth Substance Use Disorder Outpatient Referral Form

Our SUD Outpatient program offers all levels of care to include Outpatient, intensive Outpatient, DUI assessments and deferred prosecution treatment. We work closely with other programs both internally and externally to meet the needs of the individuals to include detox placement and residential coordination.

This is a voluntary program for individuals who are eligible for Medicaid, who have a primary behavioral health diagnosis, and who meet program eligibility standards.

Instructions:

- Please complete this referral form and attach a copy of your insurance card and any additional information if available.
- Submit this referral form and any attachments in person or via:
  - Email Scheduling@cihealthservices.com
  - Fax: (844) 554-3370 or (360) 748-4480
  - Postal Mail (see last page for mailing addresses.)
- CIHS will confirm receipt of the referral and will contact you within one business day of receipt of request.
- Check the county where you anticipate services being provided:

  ☐ Cowlitz ☐ Lewis ☐ Grays Harbor

- How did you hear about us? _____

Referent Information

Name of person making referral: _____Date: _____

Title (In any): _____ Relationship to Student: _____

Email Address: _____

Phone Number: _____ Fax: _____

Student / Family Information

Student Name: _____ Student Age: _____

Student Phone Number: _____

School Attending or Last Attended: _____

Grade Attending or Last Attended: _____ Date of Last Attendance: _____

Parent / Guardian's Name: _____ Phone Number: _____

Can we Contact Parent/Guardian: ☐ Yes ☐ No

Referral Details

Referral Type:

☐ School Disciplinary

☐ Concern

☐ Youth / Family Request

☐ CPS

☐ Legal. Agency? _____

Reason for Referral:

Contact / Collateral Contacts

Is there anyone expecting to know you came here, if so who?

Name: _____

Email Address: _____

Phone Number: _____ Fax: _____

Anyone you would like us to notify of your participation, if so, who?

Name: _____

Email Address: _____

Phone Number: _____ Fax: _____

Community Integrated Health Services Mailing Addresses:
Cowlitz County: 1128 Broadway, Longview, WA 98632
Grays Harbor County: 618 W. Market Street, Aberdeen, WA 98520
Lewis County: 1616 S. Gold Street, 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:

Received By: _____Date: _____

Received Via: ☐ Email ☐ Fax ☐ Mail ☐ In-Person ☐ Other_____

Provider One # _____