



Community Integrated Health Services

Youth Outpatient Referral Form

Our Youth Outpatient program offers a full spectrum of behavioral health services. Based on individuals needs we can provide mental health services to include case management, prescriber services, and peers.

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 Pacific Wahkiakum
- How did you hear about us? _____

Referent Information

Are you Self Referring? Yes No (if yes skip to next section)

Agency Name: _____ Date: _____

Contact Name: _____ Phone: _____

Contact Email Address: _____

Individual Requesting Services

First & Last Name/Avatar ID: _____ Date: _____

Birthdate: _____ Preferred Gender Pronoun: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Cell Phone: _____ Home Phone: _____

School Attending: _____

If the Youth is 13 years of age or older, they can legally consent to behavioral health treatment on their own. If the youth does not wish to have Medicaid Insurance statements or other treatment-related correspondence sent to the above mailing address please mark this box:

If the Youth is 13 years of age or older; does that Youth want their parent/guardian to have knowledge of the referral: Yes No

Parent/Guardian Information

First & Last Name: _____

Relationship: _____ Phone: _____

First & Last Name: _____

Relationship: _____ Phone: _____

First & Last Name: _____

Relationship: _____ Phone: _____

Reason for Requesting Services

- | | | |
|---|--|---|
| <input type="checkbox"/> Behavioral Health
Counseling Services | <input type="checkbox"/> Exploring Employment
Opportunities | <input type="checkbox"/> Assistance with finding
housing |
| <input type="checkbox"/> Medication Management | <input type="checkbox"/> Skill Building for Self-Care | <input type="checkbox"/> Other: |

Diagnosis (If Known) and/or Symptoms

Community Integrated Health Services Mailing Addresses:

- Cowlitz County:** 1128 Broadway, Longview, WA 98632
- Grays Harbor County:** 614 W. Market Street, Aberdeen, WA 98520
- Lewis County:** 1707 Cooks Hill Road, Centralia, WA 98531
- Pacific County:** 335 Third Street, Raymond, WA 98577
- Pacific County:** 152 First Ave North, Ilwaco, WA 98624
- Wahkiakum County:** 320 S. 3rd Street, Cathlamet, WA 98612

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 # _____