Lincoln County Child & Family Behavioral Health

Intensive Outpatient Services Referral

To be considered, the referral must be fully completed

Completed referral packet must be submitted via email to IOSS@co.lincoln.or.us

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Referral Source: _____ Date of Referral: _____
Referent Phone: _____ Referent Email: _____

Therapist: _____Therapist Phone: _____
Therapist Email: _____

Youth's Legal Name: _____Youth's Preferred Name: _____
Youth's Pronouns: _____ Youth's Preferred Language_____
Youth Phone or Email if Applicable: _____
Age: _____DOB: _____OHP Number: _____
Youth's School: _____ Youth's Grade: _____
Youth's Diagnosis: _____

Parent/Guardian Name (s): _____
Parent/Guardian's Preferred Language: _____Email: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Address: _____
Okay to Text for Scheduling? ☐ Yes ☐ No

Siblings or others who reside in the home:

Name	Age	School
_____	_____	_____
_____	_____	_____

Reason for referral. Attach another sheet if needed:

_____
_____
_____
_____
_____
_____
_____

Referent <u>must</u> present the referral packet at the IOSS meeting (Wednesdays, 12:30-1:30 pm). We'll contact you to schedule, with virtual attendance available.

Criteria / Screening

Please complete entire form by adding specifics even though they are in the MHA

1. Past / Current Treatment:

☐ Individual ☐ Skills Training
☐ Family ☐ Alcohol & Other Drug Treatment

Please explain:

_____
_____
_____
_____

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2. Current Living Situation:

☐ Biological Parent (s) ☐ DHS Temporary Lodging
☐ Resource Family ☐ Other: _____
☐ Guardian

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3. Out of Home Placement (# of changes in 12-month period):

☐ Yes
☐ No

Please explain:

_____
_____
_____
_____

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4. Any History of Higher Levels of Care:

☐ Day Treatment ☐ Acute
☐ Residential (PRTS) ☐ Behavior Rehabilitation Services (BRS)
☐ Sub-Acute ☐ Hospitalization (physical or mental health)
☐ N/A

Please explain:

_____
_____
_____
_____

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5. Risk to Self or Others:

- ☐ Suicide Attempts or Ideation
- ☐ Harm to Others / Pets
- ☐ Self-harm
- ☐ Fire Setting
- ☐ Elopement
- ☐ N/A

Please explain:

_____
_____
_____
_____

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6. Supportive Environment (guardians willing/able to engage in services, relationship between youth and caretakers):

- ☐ Yes
- ☐ No

Please explain:

_____
_____
_____
_____

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7. School Functioning:

- ☐ IEP / 504
- ☐ Absenteeism
- ☐ Expulsions / Suspensions

Please explain:

_____
_____
_____
_____

Treatment Focus

Specific goals for this referral (list the specific skills, resources, or goals to be worked on):

Client/ Family Strengths:

Client/ Family Needs & Barriers:

Additional Information/ Notes:

*Referrals must be completed and submitted electronically (typed, not handwritten)