REF: _____

EFF DATE: _____

LifeWorks NW Day Treatment Referral Form

Please send referrals to: lwnwdaytreatmentreferrals@lifeworksnw.org

Once you have emailed your referral, you should receive confirmation within one (1) business day. Once the referral form is complete and all required attachments have been submitted, the team will review the information. Typically, within two weeks of receiving all referral information (including required attachments), the referent will be notified whether or not the child/youth will be screened for the program. Once a child/youth has been screened, then a final determination will be made about whether the child/youth is accepted into the program. Children/youth who are accepted in the program usually start within a week to ten days.

Children/youth being referred must have a current day treatment authorization through CareOregon. Please confirm whether the child/youth has a CareOregon day treatment authorization in place:
☐ Yes ☐ No (If no, please get the authorization prior to submitting the referral.)

Requested program: ☐ ADTP (youth age 11 – 17) ☐ CDTP (children ages 5 – 11)

Information about the referent
Name of referent: _____
Agency/Organization name: _____
Email: _____
Phone number: _____

Information about the child/youth being referred
Name: _____
DOB: _____
Parent/Guardian name(s): _____
Parent/Guardian phone number: _____
Parent/Guardian email: _____
Address where child/youth currently lives: _____
Current treatment provider agency: _____
Current treatment provider name: _____
Current treatment provider phone number: _____
School name and district: _____
Grade in school: _____

Reason for Referral
Why is this child/youth is being referred for day treatment?

How might this child/youth benefit from day treatment?

Please provide a summary of the child/youth's current treatment services including engagement in treatment, family engagement in treatment and/or progress in treatment.

Please provide a summary of current safety/risk concerns including information such as: does the child/youth leave home and/or school without permission; does the child/youth engage in self-harming behaviors; does the child/youth experience suicidal and/or homicidal ideation; has the child/youth acted out physically (hit, pinched, bit, etc.) against others (adults or peers) either at home or at school; etc.

Please provide a list of current medications that the child/youth is taking (name of medication and dosage).

Please provide a summary of the child/youth's current functioning in school. If the child/youth has an IEP, please include that information in this section.

Is there any other information that would be helpful to consider in evaluating the referral?

Required attachments

Please attach any of the following that apply. If you do not have an item, please indicate why not.

☐ **Authorization from CareOregon**
If not included, please explain why:

_____

☐ **Most recent behavioral health assessment**
If not included, please explain why:

_____

☐ **Discharge summaries from residential or hospital placements within the past year**
If not included, please explain why:

_____

☐ **Psychiatric assessments and recommendations within the past year (including current medications)**
If not included, please explain why:

_____

☐ **Psychiatric notes from the past three months**
If not included, please explain why:

_____

☐ **Psychological assessments within the past two years**
If not included, please explain why:

_____

☐ **Current information from DHS and/or OYA**
If not included, please explain why:

_____