(EASA office use only) *Client ID #:* _____
*LWNW ERF:*_____ *Eff. Date:*_____

EASA Referral Form, LifeWorks NW – Washington County

To refer, complete this form and fax to EASA intake at (503) 684-1425. Please attach a signed release of information if possible, and include copies of any relevant assessments and/or additional information. Once faxed, call EASA intake at (503) 705-9999 to assure we have all necessary information.

CLIENT INFORMATION

Today's date: _____

Client name (LAST, FIRST) _____

DOB: _____ Age: _____ Gender:_____

Address: _____

_____

Phone: _____ cell ○ work ○ home ○ other ○ ok to leave message? **Yes** ○ **No** ○
_____ cell ○ work ○ home ○ other ○ ok to leave message? **Yes** ○ **No** ○

Primary language Client: _____ Family: _____

Race/Ethnicity Client: _____ Family: _____

REFERRANT INFORMATION:

Name: _____ email: _____

Agency Name and Address: _____

_____

Phone: _____ FAX: _____

Reason for referral: (description of current symptoms, onset, frequency, severity and duration)

Relevant cultural issues, beliefs, or practices: (immigration/acculturation issues, religious, social issues)

Additional Information that you think would be helpful (i.e. substance use, previous psychiatric tx, current rx)

(EASA office use only) *Client ID #:* _____
*LWNW ERF:*_____ *Eff. Date:*_____

Additional Client Information

Lives with: □ Family □ Alone □ Spouse □ Dorm □ Roommate □ Homeless □ other:_____

Family Members to be involved in treatment:	Age	Relationship	Alternate Contact #'s

Current employment/educational status (check): □ Working □ Unemployed □ School □ Enrolled by not attending

Name of School/Employer: _____ Last Grade completed in School:_____

Contact Name/Number of school or employer: _____

Insurance: _____ ID # (if provided) _____

Who should we contact regarding engaging client in the screening? _____

How did you hear about EASA? ***(The following information is voluntary. Its purposes are to improve our outreach efforts.)***

◯ Already familiar ◯ Mental Health Professional ◯ School Social Worker/Teacher ◯ Healthcare Professional ◯ Brochure/Poster/ Newspaper

◯ Internet ◯ Healthcare Professional ◯ Friend/ Acquaintance ◯ Family ◯ Tv/Radio

◯ Other: _____

Is this your first referral to EASA? ◯ Yes ◯ No

****

(EASA office use only)

Screening scheduled for (date): _____ at (location): _____

Outcome:

□ Screened IN, assigned to: _____ date: _____

□ Screened OUT, reason: _____ date: _____

Alternate referral provided □ YES □ NO, reason: _____

If yes, referred to: _____

□ follow up with referent complete? □ YES □ NO, reason: _____