Mental Health and Addictions Services – Youth Care Coordination

Intensive Care Coordination Referral Form

Multnomah County Health Department

Please send securely to youthcare.coordinationteam@multco.us or fax to 503-988-3328.

You can expect to hear back from a Referral Coordinator within 1 business day of sending referral. If you do not hear from us, please call 503-988-4161.

Please print clearly.

Date of Referral: _____

Referred by: _____ Agency/role: _____
Phone: _____ Fax/Email: _____

I have consulted with the guardian about this referral and they are in agreement: ☐ Yes ☐ No

Youth Information

Youth Legal Name: _____ Affirmed Name: _____
Date of Birth: _____ Age: _____ Gender: _____ Pronouns: _____
Race/Ethnicity: _____ Tribal Affiliation: _____
Primary Language: _____
Preferred method of communication: ☐ Phone ☐ Email ☐ Text

Oregon Health Plan: ☐ Yes ☐ No If yes, OHP#: _____
Other Health Insurance: ☐ Yes ☐ No If yes, insurance carrier: _____

Legal Guardian/Parent Information

Name: _____ Relationship: _____
Address: _____
Phone: _____ Fax/Email: _____
Primary Language: _____
Preferred method of communication: ☐ Phone ☐ Email ☐ Text

Physical Address of Child (If Different): _____
Name of Caregiver: _____ Relationship: _____
Phone: _____ Fax/Email: _____
Preferred method of communication: ☐ Phone ☐ Email ☐ Text

Parent (if not indicated above): _____
Address: _____
Phone: _____ Fax/Email: _____
Preferred method of communication: ☐ Phone ☐ Email ☐ Text

Required Documentation (please check and include all)

☐ Mental Health Assessment within the last 60 days

Additional Documentation (please include if available)

☐ Treatment plan/pychiatric evaulation/psychological evaluation
☐ Safety plan

Reason for Referral

Systems and Supports Information

	Provider	Phone	Fax/Email
Primary Care			
Dental Care			
Mental Health			

Current School	Grade	School Contact
IEP	**Phone**	**Fax/Email**
☐ Yes ☐ No		

Other Involved Support	Phone	Fax/Email