**YAKAMA NATION BEHAVIORAL HEALTH SERVICES**

**SERVICE REQUEST FORM**

**Date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_\_ am/pm Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referent Name: Phone Number: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Patient:** 🞎 Parent 🞎 Family Member/Friend 🞎 Social Worker

 🞎 School Counselor/Teacher 🞎 Medical Provider 🞎 Counselor 🞎 Corrections

**Name of School/Agency/Dept:**

**Type of Service:**  🞎 Individual 🞎 Family 🞎 Domestic Violence Perpetrator Treatment 🞎 Crisis Management

🞎 Anger Management 🞎 Victim Resource Program (VRP) 🞎 Rx Management 🞎 Healthy Transitions 🞎 System of Care

**Patient Name: DOB: Age**

**Address: Cell Phone #:**

**City & State: Work: IHS Chart #: \_\_\_\_\_\_\_\_\_\_\_\_\_**

 **May we identify ourselves and leave a message** **🞎 YES 🞎 NO**

**How do you identify yourself:** 🞎 Male 🞎 Female 🞎 Transgender 🞎 Other

**If Patient is Child, Who is Legal Guardian:**

**Guardian Supportive of Counseling?** 🞎 YES 🞎 NO

**Does Patient have Indian Health Service Chart?** 🞎 YES 🞎 NO **Chart #:**

**Patient Insurance:** 🞎 Medicaid/Medicare 🞎 Private Insurance **Please submit a copy for our records**

**School: Grade: Teacher:**

**REASON FOR REFERRAL OR SERVICES:**

**Is Patient on Medication?** 🞎 YES🞎 NO **Please Describe:**

**At your 1st Session, please bring your medications and/or supplements**

**\*\*\*DANGER OF HURTING SELF OR OTHERS? \*\*\*** 🞎 YES 🞎 NO **Describe:**

**Has Client contacted Behavioral Health in the past?** 🞎 YES 🞎 NO

**When? & Counselor’s Name:**

**If requesting an EVALUATION/ASSESSMENT/TESTING, please provide a Letter from the requesting Agency describing need.**

**Are there any Special Needs?** 🞎 YES 🞎 NO **Describe:**

**Are you a registered sex Offender?** 🞎 YES 🞎 NO **If so, Level:**  **Jurisdiction:**

**Preferred Appointment Times:** 🞎 8am-5pm 🞎 5pm-8pm **Therapist:** 🞎 Male 🞎 Female 🞎 Either

**Notes:**