LIGHTHOUSE
YOUTH & FAMILY SERVICES

Integrated Access Referral

PLEASE RETURN THIS FORM ALONG WITH ANY SUPPORTING RECORDS/DOCUMENTATION

Phone: (513) 487-6705 Fax: (513)221-1901 Email: IntegratedAccess@lys.org

Date of Referral:	

Check Service(s) Referral is being made for:

Include the following with referral: Insurance card, any psych evals and prior treatment records, Social Security Card, Birth Certificate (if available)

- ☐ Assessment Services
- ☐ Therapy Services
- ☐ Psychiatric Services
- ☐ Substance Use Disorder (SUD)

Referral Information - Client			
Client Legal Name:		Client Age:	
Client SSN:		Client Date Of Birth:	
Insurance Provider Name:		Insurance ID Number:	
Client Race:		Client Gender:	
Client Phone Number:		Client Email:	
Client Address:		Client Zip Code:	
Client Marital Status:		Client Tobacco Use:	
Client Education Status:		Grade Level:	
Client Primary Language:		Is an interpreter needed for services provided in English?	☐ No ☐ Yes
Client Secondary Language:			

Emergency Contact Information			
Emergency Contact Name:		Relationship to Client:	
Emergency Contact Phone:		Emergency Contact Address:	

For Clients Under 18 – Guardian/Parent Information			
Guardian/Parent:		Relationship to Client:	
Address:		Zip Code:	
Guardian/Parent Phone:		Guardian/Parent Email:	

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Guardian/Parent Preferred Method of Contact (mail, phone, or email):		Is Guardian/Parent Aware that Referral Is Being Made?	☐ No ☐ Yes

For Clients Under 18 – Additional Guardian/Parent Information (if applicable)			
Guardian/Parent:		Relationship to Client:	
Address:		Zip Code:	
Guardian/Parent Phone:		Guardian/Parent Email:	
Guardian/Parent Preferred Method of Contact (mail, phone, or email):		Is Guardian/Parent Aware that Referral Is Being Made?	☐ No ☐ Yes

If we are unable to reach a parent/guardian, who can we call to assist us?			
Name:		Phone:	
Relationship to Client (grandparent/aunt/friend, etc.)			

Client Household Information			
Estimated Household Income:		Source of Income:	
# of individuals in household:		# of individuals under 18 in household:	

Others Living in the Client's Home					
Name:		Relationship to Client:		Age:	
Name:		Relationship to Client:		Age:	

Reason for Referral/Presenting Problem:

Other Agencies Currently Involved with Client					
Agency	**Service**	**Contact Person**	**Phone**	**Email Address**	**Service Will Remain Open**
					☐ No ☐ Yes

					☐ No ☐ Yes

Medical Information - Current Medications and Dosage			
Medication:		Dosage:	
Medication:		Dosage:	
Medication:		Dosage:	
Medication:		Dosage:	
Prescribing Doctor/Psychiatrist:			
Does the client have any medical concerns:	☐ No ☐ Yes	If Yes, Explain:	

Current Diagnosis			
Source:		Date Given:	
Please List Diagnosis:			

School Information – Youth Only			
Name of School:		School District:	
Contact Person:		Phone:	
Grade:		Is there a current IEP?	☐ No ☐ Yes