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)

- ☐ Diagnostic Assessment only
- ☐ CANS only
- ☐ Individual Therapy
- ☐ Family Therapy
- ☐ Functional Family Therapy (must be enrolled in OhioRISE)
- ☐ Case Management
- ☐ Peer Support
- ☐ Substance Use Disorder (SUD)
- ☐ Medication Management

***Additional information**:*

Please supply at the time of referral or assessment any documentation such IEPs, care plans, treatments plans, previous assessments, developmental assessments, vaccinations, discharge summaries, will support diagnosis and treatment for clients.

Lighthouse does not accept third party documentation.

Lighthouse does not perform neurological assessments or psychological testing.

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:			

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

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

School Information – current or last grade completed			
Name of School:		School District:	
Contact Person:		Phone:	
Grade:		Is there a current IEP?	☐ No ☐ Yes

Reason for Referral/describe behaviors:

Other services currently involved with the client such as agencies, probation, hospital, care coordinator, or mentor. *Please complete a release of Information for each					
Agency	**Service**	**Contact Person**	**Phone**	**Email Address**	**Service Will Remain Open**
					☐ No ☐ Yes
					☐ No ☐ Yes

Medical Information - Current Medications and Dosage * show assessor current meds			
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:			