Community Integrated Health Services

School-Based Services | Cowlitz

Mental Health Referral Form

Please Select a School District or Program:

☐ **Head Start** ☐ **Castle Rock** ☐ **Kalama** ☐ **Kelso** ☐ **Longview** ☐ **Toutle**

Referring Party Information	
Date of Referral:	Outside Agency:
Referring School Name:	
☐ Early Childhood Education ☐ Elementary School ☐ Middle School ☐ High School	
Name of Person Referring:	Title:
Student Information	
Last Name:	First Name:
Date of Birth:	Grade:
Home Phone:	Cell Phone:
Email:	Gender: ☐ Male ☐ Female ☐ Transgender ☐ Intersex ☐ Decline to Answer ☐ Unknown
Communication Preference: ☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email	
Street Address:	City:
State:	Zip:
If the student is 13 years of age or older, they can legally consent to behavioral health treatment on their own. If the student does not wish to have Medicaid insurance statements or other treatment-related correspondence sent to the above mailing address, if known, please mark this box: ☐	
If the student is 13 years of age or older; does the student want their parent/guardian to have knowledge of the referral?: ☐ Yes ☐ No	
Parent/Guardian Information	
Parent/Guardian Full Name:	Parent/Guardian Phone #:
Relationship (please indicate if custodial parent, legal guardian, etc.):	
Parent/Guardian Full Name:	Parent/Guardian Phone #:
Relationship (please indicate if custodial parent, legal guardian, etc.):	
Reason for Referral	
Briefly tell us why you feel this child would benefit from our services:	
If the parent/guardian has been contacted and are waiting for CIHS to call and schedule an intake, please mark this box: ☐	

Community Integrated Health Services (CIHS)
Cowlitz County Mailing Address: P.O. Box 1054, Longview, WA 98632
Phone: (360) 261-6930 or (855) 303-4834 | **Fax**: (360) 748-4480 or (844) 554-3370
Website: www.cihealthservices.com

For Office Use Only		
Medicaid/Insurance Status & P1 Number:		
Student is Under 13 Years of Age:	☐ Yes ☐ No	
Affiliated with Other Agency:	☐ Yes, Agency:	☐ No
First Intake Date Offered:	Intake Date Accepted:	
Intake Completion Date:	First Session Date:	