PLEASE CHECK ONE:

☐Phone Call ☐Voice Mail ☐Walk In ☐Appointment ☐Fax ☐Court Ordered

YAKAMA NATION BEHAVIORAL HEALTH PROGRAM
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

Patient Name:_____ **DOB:**_____ **Age**_____
Address:_____ **Cell Phone #:**_____
City & State:_____ **Work:**_____**Message:**_____
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:**_____
Preferred Appointment Times: ☐8am-5pm ☐5pm-8pm **Therapist:** ☐Male ☐Female ☐Either
Notes:_____

_____

_____

*****FOR OFFICE USE***** **Intake Date/Intake Specialist:** _____ **Completed** ☐YES ☐NO

Assigned Therapist: _____ **Date:** _____

Patient Contacted On: _____/_____/_____ **1st Appointment Date/Time:** _____

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