WASHINGTON COUNTY
OREGON

Washington County Wraparound Referral

PLEASE BE SURE TO USE SECURE EMAIL IF SUBMITTING THIS REFERRAL ELECTRONICALLY.
wraparound@washingtoncountyor.gov
Referrals can also be faxed to the Behavioral Health Support Team at 503-846-4560.

Date of Referral: _____

YOUTH INFORMATION

Youth Name:_____ Pronouns:_____ Date of Birth:_____ Age:_____

Race:_____Ethnicity:_____Gender:_____

Oregon Health Plan: ☐Yes ☐ No If yes, OHP #: _____

Other Health Insurance: ☐ Yes ☐ No If yes, other insurance carrier: _____

Referred By:_____Agency/ Role:_____

Phone:_____Fax or Email:_____

LEGAL GUARDIAN INFORMATION

Name:_____Relationship:_____
Address:_____
Phone:_____Fax or Email:_____

Physical Address of Child (If Different):_____
Number of adults living in home:_____Number of children / youth living in home:_____
Name:_____Relationship:_____
Address:_____
Phone:_____Fax or Email:_____

SYSTEMS INVOLVEMENT

CHECK ALL THAT CURRENTLY APPLY: ☐Mental Health; ☐Special Education; ☐DHS Child Welfare; ☐ Intellectual/Developmental Disabilities; ☐Juvenile Justice/ OYA; ☐Substance Abuse/ Addictions; ☐Complex Physical Health ☐ SAIP/ SCIP ☐ Psychiatric Residential Treatment Services (PRTS); ☐CSEC/SAGE: ☐ Other:_____

Department of Health and Human Services – Behavioral Health
5240 NE Elam Young Parkway, Suite 150, MS-70, Hillsboro, OR 97124
Phone: (503) 846-4528 Fax: (503) 846-4560 washingtoncountyor.gov

Goals for Care Coordination:

☐ Develop an individualized plan based on strengths and needs; ☐ Facilitate multi-system team meetings;
☐ Coordinate system navigation and advocacy; ☐ Engage family, system partners and natural supports;
☐ Engage culturally and linguistically responsive supports; ☐ Safety and crisis planning;
☐ Other _____

SYSTEMS AND SUPPORTS INFORMATION

Please complete this section to the best of your ability. List all people currently involved with the Youth or Family, Including Family or Community Supports. Please check if you have attached a signed Release of Information, which is voluntary and not required to be screened for Care Coordination.

Primary Care Provider (REQUIRED): _____
Phone:_____ Fax or Email:_____ ☐ Signed Release of Information

Dental Care Provider (REQUIRED):_____
Phone:_____ Fax or Email:_____ ☐ Signed Release of Information

Current Mental Health Agency:_____ Therapist:_____
Phone:_____ Fax or Email:_____ ☐ Signed Release of Information

Current School:_____ Grade:_____
Phone:_____ Fax or Email:_____ ☐ Signed Release of Information

Other Involved Supports:_____ Role:_____
Phone:_____ Fax or Email:_____ ☐ Signed Release of Information

Other Involved Supports:_____ Role:_____
Phone:_____ Fax or Email:_____ ☐ Signed Release of Information

☐ **Mental Health Assessment (or update) completed within one year prior to making the referral.**

Diagnoses (name and ICD-10 code)

_____
_____
_____