Luzerne Intermediate Unit 18 - Blended Case Management Referral Form

Client Name: _____

DOB:_____ **SSN:** _____ **LIU Program** *(if applicable)*_____

Home Address: _____

Parent/Caregiver Name: _____ **Phone #:** _____

School District: _____**School Name:**_____ **Grade:** _____

Insurance Information: _____

Please attach proof of behavioral health diagnosis (F code)
Examples include intake evaluation, psychiatric or psychological evaluation or Dr., RN or therapist note.

Other Services *(Please include all known services past and current)*

	Drug & Alcohol Issues	**Specify:**
☐	**Children & Youth Services**	**Caseworker:** **Phone:**
☐	**Legal**	**Probation Officer:** **Phone:**
☐	**Outpatient Therapy**	**Provider:** **Therapist/Phone:**
☐	**Intensive Behavioral Health Services**	**Provider:** **Staff Supporting: ☐ BC/MT ☐ BHT ☐ BCBA/BC-ABA ☐ BHT-ABA**
☐	**Prior Psychiatric Hospitalizations List:**	
☐	**Other:**	

Referral Source Name: _____ **Agency/Dept.:** _____
Referral Phone: _____ **Email:** _____
Is consumer and/or family aware of and in agreement with referral? ☐ Yes ☐ No

Current needs/reasons for referral. Please be specific as to what needs are:

Mental Health
Medical
Financial
ADL's
Social/Recreational
Drug & Alcohol
Educational/Vocational
Natural Supports
Housing
Legal

Primary Care Physician: _____ **Address:** _____
Psychiatrist: *(if applicable)* _____ **Address:** _____

Please return all completed referrals by fax to 833-642-0455 or by email to ksprague@liu18.org