www.chnk.org
GetHelp@chnk.org

Phone: 859.292.4140
Fax: 859.261.0490

REFERRAL FORM

Referral Source Name *(Point of Contact)*:	Referral Source Agency / Organization Name:	Date:

Referral Source Type: ☐ Youth/Self ☐ DCBS/Child Welfare ☐ Health/Medical Provider
☐ Parent/Legal Guardian ☐ School Other (please specify):

Referral Source email: _____ *(I give CHNK permission to email me by providing my email address. I understand that I can opt out at any time.)*	Referral Source Ph#:

Reason for Referral *(Please check all that apply)*:

☐ Behavior Problems at Home ☐ Behavior Problems / Disciplinary Referrals at School ☐ Court / DJJ Involvement
☐ Drug and/or Alcohol Use ☐Mental Health Concerns / Symptoms ☐ Runaway Behaviors
☐ Skipping School / Truancy ☐ Tobacco Use ☐Other *(*please specify)*: _____

Currently in services with another provider *(*If yes, who?)*

PROGRAM REFERRED TO: ☐ Residential ☐ Outpatient ☐ Partial Hospitalization ☐ Intensive Outpatient Program
☐ Target Case Management ☐ Couples Therapy ☐ Medication Management ☐ Day Treatment ☐ other _____

TYPE OF APPOINTMENTS: ☐ In-Person ☐ Telehealth

Client Information:

Legal Name:	DOB:	SSN:

Alias or Nickname:	Ethnicity: Race:	Gender Identity: ☐ Female ☐ Male ☐ Transgender

Street Address:	City, State, & Zip:

School Name & District:	School County:	Youth's Grade:

Make sure to list the contact phone number and email below. Thank you.

Parent/Guardian Information (If Applicable):

Primary Caregiver / Legal Guardian Name(s):

Relationship to Youth: ☐ Self ☐ DCBS/State Worker ☐ Grandparent ☐ Legal Guardian ☐ Parent ☐ Other

Parent / Guardian's Street Address: ☐ ***Same as youth***	Parent / Guardian's City, State, Zip:

Primary Ph#:( )	**Alternate Ph#: ( )**	**Email: _____** ***(I give CHNK permission to email me by providing my email address. I understand that I can opt out at any time.)***

Insurance Information: INCLUDE A COPY OF THE INSURANCE CARD (front and back)

Primary Insurance:	**Member ID#:**	**Group #:**
Subscriber's Name and Address / Name on Card:		**Subscriber's DOB:**
Primary Insurance Phone #:	**Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child**	
Secondary Insurance:	**Member ID #:**	**Group #:**
Subscriber's Name / Name on Card:		**Subscriber's DOB:**
Secondary Insurance Phone #:	**Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child**	
CHNK USE ONLY	**Date Referral Received:**	

Updated 7/25/2023