www.chnk.org
GetHelp@chnk.org

CHNK BEHAVIORAL HEALTH

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: _____ *(By providing my email address, I give CHNK permission to email me. 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: ☐ Outpatient ☐ Residential ☐Intensive Outpatient Program ☐ Day Treatment ☐ Targeted Case Management

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:
Email: _____ *(I give CHNK permission to email me. I understand that I can opt out.)*		

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: _____ *(By providing my email address, I give CHNK permission to email me. I understand that I can opt out at any time.)*

Insurance Information: INCLUDE A COPY OF THE INSURANCE CARD.

Primary Insurance:	**Member ID#:**	**Group #:**
Subscriber's Name / Name on Card:		**Subscriber's DOB:**
Primary Insurance Phone #:	**Relationship to Subscriber: ☐ Self ☐ Child**	
Secondary Insurance:	**Member ID #:**	**Group #:**
Subscriber's Name / Name on Card:		**Subscriber's DOB:**
Secondary Insurance Phone #:	**Relationship to Subscriber: ☐ Self ☐ Child**	

CHNK USE ONLY	**Date Referral Received:**
Contact Attempt #1 Date:	**Results:**
Contact Attempt #2 Date:	**Results:**
Contact Attempt #3 Date:	**Results:**