

HTC 08012025

Referral & Consent

Free Mental Health Screenings | Statewide Email Referrals To: info@haventreatmentcenter.com

Call: 360-255-5993 | Fax: 360-768-5992

Referral Form

Client Name: Date of Birth:	CLIENT INFORMATION ☐ Child	(5-12 yrs) ☐ Adolesce	ent (13-17yrs)		
Address:	Client Name: Date of Birth:				
Insurance Provider:Subscribers Name:	Parent/Guardian (If Applicable):	P	hone#:		
Member ID / Group ID:	Address:	City:	State:	Zip:	
Recommendations for the Following Service (s) Free Mental Health Screening Initial Assessment Partial Hospitalization Intensive Outpatient Programming Group programming includes Individual Therapy, Family Therapy, and Medication Management part of programming. Residential Treatment Center (Must be Referred by Child Protective Services) Diagnosis/Concerns: CONSENT ***** PLEASE COMPLETE THIS SECTION**** Client's Release of Information: I authorize referral source to communicate with Haven Treatment Center for the purpose of tele screening, communication, and scheduling my appointment. An authorization to release protected health information form will be required to discuss treatment. I am aware that any missed appointments scheduled will be communicate with referring physician or referral source. Client Signature: Date: Date:	Insurance Provider:	Subscriber	Subscribers Name:		
Recommendations for the Following Service (s)	Member ID / Group ID:				
□ Initial Assessment □ Partial Hospitalization □ Intensive Outpatient Programming Group programming includes Individual Therapy, Family Therapy, and Medication Management part of programming. □ Residential Treatment Center (Must be Referred by Child Protective Services) Diagnosis/Concerns: CONSENT ***** PLEASE COMPLETE THIS SECTION**** Client's Release of Information: I authorize referral source to communicate with Haven Treatment Center for the purpose of tele screening, communication, and scheduling my appointment. An authorization to release protected health information form will be required to discuss treatment. I am aware that any missed appointments scheduled will be communicate with referring physician or referral source. Client Signature: □ Please check box if client provided verbal consent. Referral Source Information □ ISD□ Court □ Provider □ Other Person Making Referral: □ Referral Organization: □ Phone# Office Contact Person: □ Fax# Email: Haven Treatment Center Area □1st Attempt □ 2nd Attempt □ 3rd Attempt □ Appointment Scheduled: □ Date: □ Time: □ Client Unable / Declined to schedule: Reason: □ Note: □ Note: □ Note: □ Note: □ Intensive Output Declined to schedule: Reason: □ Time: □ Time: □ Time: □ Client Unable / Declined to schedule: Reason: □ Note:	Email:				
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Person Making Referral:	with referring physician or refer	rral source.			
Referral Organization:Phone# Office Contact Person:Fax# Email: Haven Treatment Center Area	Referral Source Information	□ ISD□ Court □ Pro	ovider Other		
Office Contact Person:Fax#	Person Making Referral:	-			
Haven Treatment Center Area	Referral Organization:		Phone#		
Haven Treatment Center Area ☐ 1st Attempt ☐ 2nd Attempt ☐ 3rd Attempt ☐ Appointment Scheduled: ☐ Date: ☐ Time: ☐ Time: ☐ Note: ☐ Note: ☐ Date: ☐ Date	Office Contact Person:		Fax#		
Haven Treatment Center Area ☐ 1st Attempt ☐ 2nd Attempt ☐ 3rd Attempt ☐ Appointment Scheduled: ☐ Date: ☐ Time: ☐ Time: ☐ Note: ☐ Note: ☐ Date: ☐ Date	Email:				
	Haven Treatment Center A Appointment Scheduled: Client Unable / Declined to sche	Area □1st Attempt Date: edule: Reason:	□ 2nd Attempt Time:		
Haven Treatment Center team member completing this document:					

www.haventreatmentcenter.com