adapt
Integrated Health Care

Wraparound Referral

Referred by:_____ **Referral Date:**_____

Youth Name:_____ **Date of birth:** _____

Parent/Guardian:_____ **Phone:**_____

Youth Placement:_____**Phone (if different):** _____

I have consulted with the family/guardian about this referral and they agree: ☐ YES ☐ NO

☐ **OHP member**

☐ Currently enrolled in services with Compass Behavioral Health

Therapist: _____

Tribal Affiliation:

Receives services from a child serving agency other than Mental Health (check all that apply):

Special Education (IEP) ☐ Juvenile Justice/OYA ☐ DHS Child Welfare ☐ Tribal ☐ Residential Placement ☐
Substance Abuse/Addictions ☐ Intellectual/Developmental Disabilities ☐ Complex Medical Needs ☐ Other (detail below) ☐

Demonstrates Social, Emotional, or Behavioral issues (check all that apply):

☐ Threats of harming self or others
☐ Significant risk of losing placement/Placement disruptions
☐ Significant decrease in functioning
☐ Recent Hospitalization (ER, Acute, or Sub-acute)
☐ Residential Facility (BRS or PRTS)
☐ History of Substance abuse
☐ Aggressive behaviors
☐ Sexualized behaviors
☐ Family issues
☐ Other _____

Reason for referral:

Return form to: wraparound@adaptoregon.org

Strengths of youth/family:

Barriers:

Other Information/ Notes: