

Date of Referral: \_\_\_\_\_

**Spokane County WISE Referral Form**

**Referral process**

There are multiple agencies in the Spokane area who offer WISE services. These agencies work together to serve families promptly. \*Please initial by all of the agencies listed below with whom you are in agreement with having access to this referral. Initials will indicate your agreement, as the child's parent or guardian, for the initialed agencies to communication with one another to coordinate your child's services. Please **only** initial agencies from which you are willing to receive service from and give permission for communication between. You may also contact an agency by phone to make a referral in lieu of submitting a fax.

<input type="checkbox"/> <b>Daybreak Youth Services</b> Phone: 509-475-4651 Fax: 509-835-4272	<input type="checkbox"/> <b>Excelsior Youth Center</b> Phone: 509-559-3100 Fax: 509-328-7582
<input type="checkbox"/> <b>Frontier Behavioral Health</b> Phone: 509-838-4651 ext. 377737 Fax: 509-363-2774	<input type="checkbox"/> <b>Institute for Family Development</b> Phone: 509-328-3802 Fax: 509-328-3871
<input type="checkbox"/> <b>Lutheran Community Services</b> Phone: 509-747-8224 Fax: 509-747-0609	<input type="checkbox"/> <b>Passages</b> Phone: 509-892-9241 Fax: 509-892-9251

All children/youth that meet the CANS algorithm and are eligible for Medicaid funded mental health services will be offered entry into WISE or WISE-like services.

**Note: Per the WA State DSHS Division of Behavioral Health and Recovery directive, the Child and Adolescent Needs and Strengths (CANS) Screen is considered a coordination of care activity that does not require an Authorized Release of Information to process.**

Child/Youth Information			
Child/youth Name:		Date of birth:	
Parent/Guardian:			
Address:			
Provider One #:		Phone #:	
Social worker name:			
Has this youth had a CANS screen in the last 30 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes, with:		

Referring Agency Information			
Agency:		Phone #:	
Provider name:		CLIP/PCCA	<input type="checkbox"/> Yes <input type="checkbox"/> No

Special Considerations		
Risk factors (please check all that apply):		
<input type="checkbox"/> Physical aggression	<input type="checkbox"/> Sexualized behavior	<input type="checkbox"/> Delusions/hallucinations
<input type="checkbox"/> Past suicide attempt	<input type="checkbox"/> Suicidal ideation	<input type="checkbox"/> Homicidal ideation
<input type="checkbox"/> Drug use/abuse	<input type="checkbox"/> Fire starting	<input type="checkbox"/> Animal abuse

Notes: