Safe Space
CHILDREN'S ADVOCACY CENTER OF THE GORGE

Mind Body Youth Program Referral Form

206 Wasco Loop, Hood River, OR, 97031 | Phone: 541-436-2960 | Fax: 541-436-2961

Patient Information:

- **Full Name:** _____
- **Date of Birth:** _____
- **Gender:** _____
- **Address:** _____
- **Phone Number:** _____
- **Email:** _____

Parent/Guardian Information:

- **Name:** _____
- **Address:** _____
- **Phone Number:** _____
- **Email:** _____

Referral Source:

- **Referring Agency:** _____
- **Referring Provider:** _____
- **Phone Number:** _____
- **Fax Number:** _____
- **Email:** _____

Insurance Information:

- **Insurance Provider:** _____
- **Policy Number:** _____
- **Group Number:** _____

Reason for Referral:

- **Primary Diagnosis:** _____
- **Secondary Diagnosis (if any):** _____
- **Presenting Issues/Symptoms:** _____
- **Relevant Medical History:** _____
- **Current Medications:** _____
- **Allergies:** _____

Services Requested:

- **[ ] Individual Therapy**
- **[ ] Group Therapy**
- **[ ] Family Therapy**
- **[ ] Medication Management**
- **[ ] Other (please specify):** _____

Additional Information:

- **Previous Mental Health Treatment:** _____
- **Current Support Systems:** _____
- **Risk Factors (i.e., suicidal ideation, self-harm):** _____
- **Special Considerations (i.e., cultural, language needs):** _____
- **Other Organizations Providing Services:** _____

Consent: I hereby consent to sharing the above health information with SafeSpace Mind Body Youth Program.

- **Patient Signature:** _____
- **Date:** _____
- **Parent/Guardian Signature (if applicable):** _____
- **Date:** _____

Fax Completed Form to Attn: MBYProgram at 541-436-2961