



# REFERRAL FORM

**Kinship House**  
1823 NE 8<sup>th</sup> Ave., Portland, OR 97212  
phone (general): 503.460.2796  
phone (intake): 503.724.6878  
fax: 503.460.3750

Today's date: \_\_\_\_\_  
Date you want services to start: \_\_\_\_\_  
Next court date (if applicable): \_\_\_\_\_

**Office use only:**  
case #: \_\_\_\_\_ therapist: \_\_\_\_\_  
date \_\_\_\_\_ first contact \_\_\_\_\_  
received: \_\_\_\_\_ date: \_\_\_\_\_

**Billing Source:**

- System of Care (SOC)
- Private Insurance
- Administrative Medical
- KH Scholarship
- Oregon Health Plan
- Private Pay

**Referred by:**

- parent:  adopt  birth  foster
- caseworker (county/branch:) \_\_\_\_\_
- other: \_\_\_\_\_

**Services Requested:**

individual therapy  family therapy  assessment (due date): \_\_\_\_\_  other: \_\_\_\_\_

**Child(ren) to be referred (please provide additional information on following pages, one page per child):**

Child #1 name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Child #2 name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Child #3 name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Child #4 name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Child #5 name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Referral Source:**

Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Relation to child: \_\_\_\_\_

**Description of current concerns:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Child Information** Have you ever been to Kinship House?  yes  no

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  m  f  
Race/Ethnicity:  American Indian or Alaskan Native  Black or African American  White  Asian  
 Native Hawaiian or Pacific Islander  Hispanic or Latino  Other: \_\_\_\_\_

**Parent Information**

Parent(s): \_\_\_\_\_  adoptive  birth  foster  guardian/permanent provider

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_  cell  home  work Email: \_\_\_\_\_

Phone: \_\_\_\_\_  cell  home  work

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**Community Resources** (please complete as applicable):

**Caseworker:** \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**School:** \_\_\_\_\_ Teacher \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Doctor:** \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Attorney:** \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**CASA:** \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Therapist:** \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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**Doctor:** \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Attorney:** \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Doctor:** \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

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Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

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Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Billing Information** (please complete as applicable):**Private Insurance**

Insured's name:	_____		
Insured's address:	_____		
Insured's DOB:	_____	Relationship to child:	_____
Insurance Company:	_____	Phone:	_____
Address:	_____		
Group #:	_____	Insurance ID:	_____

**Assessments (DHS Referral Only)**

Assessments are generally paid for with Administrative Medical Dollars. Please send forms OMAP 729 and CF0501A. The following is a list of codes typically used, but is not a complete list. Please contact the resource representative at your branch for additional information. **Please attach case records, specific questions to be addressed, a list of individuals to be contacted for assessment purposes, and releases of information to this referral. Referral date will be considered date that all information, including vouchers, has been received by Kinship House.**

**Individual Assessment:**

90801 Comprehensive Evaluation (please indicate without testing)  
 99244 Case record consultation (case review and consultation with field staff)  
 90889 Preparation of Report

**Sibling Assessment:**

PC005 Sibling Interaction (2 children)  
 PC006 Each additional child  
 99244 Case record consultation  
 90889 Preparation of report (One code per report. Complete separate vouchers if additional reports are needed)

**Parent/Child Assessment:**

PC001 One parent / one child  
 PC002 One parent / two children  
 PC003 One parent / three children  
 PC004 Two parents / one child  
 PC006 Each additional child  
 99244 Case record consultation  
 90889 Preparation of report (One code per report. Complete separate vouchers if additional reports are needed)

**Parental Assessment:**

H1011 Parental Assessment  
 99244 Case record consultation  
 90889 Preparation of report (One code per report. Complete separate vouchers if additional reports are needed)

**Our Intake Process**

The Kinship House treatment team meets weekly to review new referrals. Referrals are assigned in order of receipt and also based on level of urgency. Your assigned therapist will contact you within two weeks of case assignment to schedule an initial appointment. Please feel free to contact Kinship House by phone or email if you have not heard from your therapist within this time frame, or if needs become more urgent. Thank you for your referral, and we look forward to working with you.

**Confidentiality Notice**

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