Sunshine Behavioral Health
1102 S Raymond Rd, Spokane Valley, WA 99206
(509)892-4342

ARTF Referral

PERSONAL INFORMATION

Name: _____ Request Date: _____

Date of Birth: _____ Gender: _____

Social Security Number: _____ Provider One Number: _____

MCO: _____

Guardian/POA: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

Payee: _____ Phone Number: _____

HEALTH PROVIDERS

Behavioral Health Provider: _____ Phone Number: _____

Prescriber: _____ Phone Number: _____

Diagnosis: _____

MEDICAL HISTORY/ISSUES THAT MAY IMPACT PLACEMENT

_____

_____

CURRENT LIVING SITUATION:

_____

BEHAVIOR HISTORY

	Yes	No		Yes	No
Current Thoughts of Self-Harm/Suicide			Current Thoughts of Harming Another Person		
Past Thoughts of Self-Harm/Suicide			Past Thoughts of Harming Another Person		
Prior Suicide Attempts/If yes #_____			History of Homicide/Manslaughter		
Probation/Parole Involvement			History of Injuring Another Person		
Current/History of Injuring Animals			School Issues		
Recent Trauma Exposure			Current Substance Use/Abuse		
Recent Job Loss			Past Substance Use/Abuse		
Victim of Violence/Abuse			Perpetrator of Violence/Abuse		
Access to Guns/Weapons			Other (specify):		

For any risk/safety concerns marked yes, please explain. _____

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MEDICAL NECESSITY

Risk of Harm:

_____

_____

Functional Status:

_____

_____

Co-Morbidity:

_____

_____

Recovery Environment Stress/Support:

_____

_____

Treatment and Recovery History:

_____

_____

Engagement:

_____

_____

Additional Comments:

_____

_____

_____

_____

Please include a copy of clinical assessment, applicable progress notes, crisis plan, recovery plan, and medication list. Fax to 509-352-5320 or email JenniferC@shfi.com . Attention Jenn.

Clinician Signature: _____ Date: _____