

**Eastern Oregon Coordinated Care Organization
Care Coordinator**

2301 Cove Avenue
La Grande, Oregon: 97850

Danielle Stolk WCC
Tylo Colflesh WCC

Phone 541.962.8841
Phone 541.962.8808

COORDINATED CARE INITIAL REFERRAL FORM

Date of Referral:	Release of Information signed? Please complete for follow up with referring agency/individual. Yes _____ No _____
Name of Youth:	Date of Birth:
Address:	Age:
City, State, Zip:	Gender:
Phone #:	Email:
Mother's Name:	Father's Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone #:	Phone #:
Email:	Email:
Legal Guardian:	Phone #:
Address:	City, State, Zip:
Email:	

Family

Name	Age (if Youth)	Relationship to youth?
Person Making Referral:	Phone #:	
Referral Agency:	Email:	

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Please give a detailed description of the behaviors and concerns that prompted this referral (criminal history, school issues, family dynamics, current living situation, etc.):

Programs that the youth/family have participated in or are currently participating in:

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**SOCWI
Screening Checklist
Union County, Oregon**

Date: _____

Youth's Name:	Yes	No	Comments
Must Meet the Following Criteria:			
Youth and family are engaged in Mental Health services through Center for Human Development (Main Office, Union-La Grande-Elgin SBHC/SBMH, Elgin Family Clinic)- A Mental Health Assessment and Treatment Plan must be current.			
Must Meet One of the Following Criteria:			
Youth at risk of residential treatment outside the community for behavior issues, is currently in residential treatment, or has regressed upon return from a treatment facility outside the community.			
Youth is involved with at least 1 child serving systems/agencies, e.g. Child Welfare, Juvenile Justice, CARE coordinators, Schools, Developmental Disabilities, etc.			
Additional Supporting Criteria (check all that apply)			
Youth has a family*			
Significant risk of losing current placement and/or multiple moves within the system			
Youth is displaying emotional and behavioral issues and there are social concerns			
School disruption due to suspension and/or expulsion			
Permanency status in question (disrupting adoption, pre-finalized adoptions, new relative placements, etc.)			
Elevating risk of harm to self or others including sexualized behaviors, fire setting etc.			
Does the youth have Oregon Health Plan (EOCCO/GOBHI/Open Card)			
Youth has medical condition/s that may be impacting/ contributing to behavioral challenges.			

*"Family" means the biological or legal parents, siblings, other relatives, foster parents, legal guardians, spouse, domestic partner, caregivers and other primary relations to the individual whether by blood,

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adoption, legal or social relationships. Family also means any natural, formal or informal support persons identified as important by the individual.

Date: _____

Referral Outcome

Youth's Name:		
Family is screened into Wrap:		
Assigned to the following Wrap Care Coordinator:		Danielle Stolk
		Tylo Colflesh
Family is Not screened into Wrap:		
Engagement was attempted but was not successful. Describe:		
Family declined to participate in services. Explain:		
Family is screened into alternate services. Explain:		Outpatient Mental Health
		ISA/ Care Coordination:
		Other:

* If ROI is in place, give copy of completed Outcome to referring agency/individual.