A black background with blue and orange dots

Description automatically generated

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

**Care Nav Referral Form**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *CONTACT INFORMATION* | | | | | |
| ***Name:*** | | ***DOB:*** | | ***Preferred Language:*** | |
| ***Phone Number:*** | ***Email(s):*** | | | ***Preferred Contact Method:***  ☐ Phone Call  ☐ Text  ☐ Email | |
| ***Address:*** | | | ***Zip code:*** | | ***County/Jurisdiction:*** |
| ***Parent/Guardian Name(s) and Phone Number(s) (if applicable):*** | | | | | |
| ***Referral Source (Self, Formal/Professional Support, Mental Health Services, Outpatient, etc.) (if applicable):*** | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***REASON FOR SERVICES*** | | | | | | |
| **Reason for Service/Service(s) Requested:** | Mental Health/Care  Substance Use Disorder (SUD)  ER/Crisis  Challenging Behaviors  Family Support  Other: | | | | If checked “other”, please explain: |
| **Is the youth currently enrolled in any other services?** | Yes | No | If yes, what services? | | |
| **Has the youth used/accessed any other services in the past?** | Yes | No | If yes, what services? | | |
| **Does the youth currently have health insurance?** | Yes | No | If yes, what insurance? | | |
| **Where does the youth currently access healthcare (PCP, urgent care, emergency visits, etc.)?** |  | | | | |
| **Does the youth currently have transportation?** | Yes | No | If yes, what transportation utilized (Car, bus, etc.)? | | |
| **Please list any additional information/barriers:** |  | | | | |
| **NVFS Conexiones: Youth would benefit from services tailored for Spanish speaking immigrant families, with flexibility for home visiting and later hours.** | | | |  | |

**Connect with one of our Care Navigators**

Phone: 703-468-0040

Email: youthcarenav@hopelinkbh.org