Fora Health™
TREATMENT & RECOVERY

Fora Health
4411 NE Emerson St.
Portland, OR 97218
Main (503) 535-1151
Email kellie.fellen@forahealth.org

Fora Health Youth Program Referral Form

Fill out the form and fax to 503-535-1163 put "Attention Youth Admissions", please also fax most recent drug and alcohol assessment, mental health assessment and updated med-list (if applicable) to that fax number as well.

Any questions contact Kellie Fellen at (503) 535-1164 or kellie.fellen@forahealth.org

General Information

Appointment date/time: ______________________

Date: ____________ **Form completed by:** ______________________

Patient Name: ______________________

DOB: ____________ **Age:** ________ **SSN:** ______________________

Gender: ☐ Female ☐ Male ☐ Trans Female/Trans Woman/Affirmed Woman
☐ Genderqueer/Gender Non-Conforming ☐ Trans Male/Trans Man/Affirmed Man
☐ Agender/Without Gender ☐ Declined ☐ Additional Category: ____________

Guardian name(s): ______________________

Phone number(s): ______________________

Email: ______________________

Mailing address: ______________________

Present concerns: ______________________

____

____

Services desired: ______________________

Youth's SOC/level of engagement: ______________________

Interpretive services needed (language, hearing, other)? ☐ Yes ☐ No Specify: ______________________

Referent Name: ______________________

Referent Occupation: ______________________

Referent Email: ______________________

Referent Phone: ______________________

Substance Use Information

Drug(s) of Choice: ______________________

Previous diagnosis assigned: ______________________

Most recent use/pos UAs: ______________________

Previous treatment (include dates): ______________________

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Mental Health Information

MH diagnosis concerns/issues:

☐ Anxiety ☐ Bipolar Disorder ☐ Borderline Personality Disorder
☐ Depression ☐ Psychosis ☐ PTSD
☐ Schizophrenia ☐ Trauma ☐ Schizoaffective Disorder
☐ Other: ______________________

Suicidal ideation (check any that apply): ☐ History ☐ Current ☐ Plans ☐ Attempts

Comments: ______________________

Self harm (check any that apply): ☐ History ☐ Current *Type*: ______________________

Eating disorder (check any that apply): ☐ Purging ☐ Restrictive eating ☐ Underweight

Behavioral issues/aggression: ______________________

Medical Information

Current Medications:

Medication Name and Indication	

Allergies? ☐ Yes ☐ No *if yes,* please list out allergies: ______________________

Primary doctor/clinic: ______________________

Most recent medical/hospital visit: ______________________

Medical history: ______________________

____

Medical concerns/issues: ______________________

____

Academic Information

Current/Previous School: ______________________

Grade level: __________

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Legal Information

Parole/Probation Officer name: ______________________ **County:** ____________

Parole/Probation Officer phone: ______________________

Legal concerns/charges: ______________________

____

Discharge Plan

Outpatient (where/who): ______________________

Home (where/who): ______________________

Insurance Information

Method of Payment: ☐ None ☐ Self-Pay ☐ Insurance: ______________________

Policy info (ID/Group): ______________________

Insurance phone number (for providers): ______________________

Policyholder Name: ______________________

Policyholder Phone: ______________________

Policyholder Address: ______________________

Policyholder DOB: ____________ **Policyholder gender:** ____________