Three Rivers Therapy, LLC

10505 West Clearwater Ave, Kennewick WA 99336
(p) 509.378.5553 (f) 509.579.4088

Three Rivers Therapy WISe Referral Form

Date of Referral: _____

Referral Process

1. This form should be completed and submitted to Three Rivers Therapy WISe Team, for all referrals for WISe services.
2. All children/youth who meet the CANS algorithm and are eligible for mental health services will be offered entry into WISe or WISe-like services.

Note: Per the WA State DSHS Division of Behavioral Health and Recovery directive, the Child and Adolescent Needs and Strengths (CANS) Screen is considered a coordination of care activity that does not require an Authorized Release of Information to process.

Child/Youth Information

Child/Youth Name: _____ Date of Birth: _____

Parent/Guardian: _____ DCFS Social Worker (If applicable): _____

Address: _____ Phone No: _____

_____ Provider One Number _____

☐ Youth/Family notified of future WISe Agency contact ☐ Caregiver speaks alternate language: _____

Referring Agency Information

Agency: _____

Provider Name: _____

Phone No: _____

NOTES: _____

Fax completed form to: Jillian "Jill" Balsz at (509) 579-4088 or E-Mail to: Jillian@3riverstherapy.com

Referral Outcome (WISe Staff Only):	☐ Accepted into WISe; intended start date:	☐ Family / Youth Declined
☐ Referred to Outpatient / Lower LOC	☐ WISe Program at Capacity	☐ Other: