Lower Sioux Indian Community

Kinship Model Referral Form

Date	Click or tap to enter a date.
Worker Information:	
Name	
Phone Number	
Connection to client	
Client Information:	
Name	
Date of Birth	
Address	
Phone Number	
Health Insurance	☐ **Yes** ☐ **No**
Minor Client Information	
Who has custody	☐ Parent ☐ Agency ☐ Guardian Name(s)
Guardian's Phone Number	
Guardian's Address	
Collateral Information	

Reason for referral:

Statement of substance use and abuse history:

Statement of current known mental health diagnosis, symptoms, medications, and providers:

Release of Information is required to pursue referral.

Woniya Kini Behavioral Health Services Kinship Model Cultural Facilatotor will make first attempt contact with the client within the first two buisiness days of receiving referral.

Kinshihp Model Cultural Facilitator will provide weekly updates to the worker as long as there is agreement of such communication between the client and workers.

Internal use only: _____ _____

Date received Initials