



Date Referred: \_\_\_\_\_

## Telecare Community Alternatives Team Thurston & Mason Co. TCAT Referral

### Client Individual Demographics

Client Name	
Legal Name	
Gender & Pronouns	
Date of Birth	
Address & Phone Number (if homeless please note)	
Medicaid or Medicaid Eligible?	Provider 1:
Current Diagnosis	
Reason for Referral	What is the client needing support with? What kind of mental health symptoms are they experiencing? Any suicidal or homicidal ideation? History of violence, sex offense, substance use?
Additional Referrals made? Please provide contact information and appointment times	
Discharge Date	

### Referent Contact Information

Name/Agency	
Phone number	
Fax number	

**Please fax referral to 360-357-2819 for Thurston County or 360-462-3017 for Mason County You may also email referrals directly to [tmtcatreferrals@telecarecorp.com](mailto:tmtcatreferrals@telecarecorp.com)**

**Highlighted information is required**