Mariposa County Behavioral Health and Recovery Services Referral

Mariposa County Human Services
Growing Strong, Safe, Healthy Communities

Please complete and return to:
Medical Records Department Fax to: 209-742-0996

************For URGENT referrals with active suicidal ideation or plan************
Please call Mariposa Crisis Line at 209-966-7000 or 911

Referral Date: _____
Referring Source: ☐Probation ☐Court ☐ Jail ☐JCF ☐Sheriff ☐CWS ☐BH ☐School ☐Other: _____
MINOR'S ONLY - Client is currently: ☐At risk for Out-of-Home Placement ☐In Placement ☐N/A

Referring Source Contact Person: _____ **Phone #:** _____

Referral To: ☐ **Mental Health Evaluation/Assessment:** Determine what services are needed
☐ **Substance Use Disorder Services:** Addiction and Substance abuse treatment
☐ **Whole Person Care:** Collaborative program to improve physical health and well-being
☐ **Other**_____

CLIENT INFORMATION:

Name: _____ Age: _____ Gender: ☐M ☐F ☐Other

Date of Birth: _____ Social Security #: _____

Address: _____ Phone #: _____

Is client homeless or at risk of being homeless? ☐Yes ☐No

Can client be contacted at number listed above? ☐Yes ☐No Is it okay to leave a message? ☐Yes ☐No

Parent/Legal Guardian: _____Phone #: _____

Is client aware of referral? ☐Yes ☐No Language: _____ Is interpreter required? ☐Yes ☐No

Insurance Information:

Medi-Cal: ☐Yes ☐No ID#: _____ Insurance: ☐Yes ☐No ID#: _____

Primary Care Physician: ☐JCF ☐Mariposa Family Med ☐Horizons ☐Clinic 3 ☐Dr. Endress ☐Other: _____

Current Agency Supports ☐ Probation ☐ Child Welfare ☐ School ☐ IEP ☐ Other: _____

CLINICIAL FEATURES:

If imminent risk to self or others contact Crisis or 911

☐**Suicidality:**
Ideation: ☐No ☐Active ☐Passive
Date of last attempt: _____
☐**Self-Harm Behavior:**
Current? ☐Yes ☐No
Past? ☐Yes ☐No
☐**Aggressive Behavior:** ☐Yes ☐No
☐**Arson/Fire Setting:** ☐Yes ☐No
☐**Inappropriate Sexual Behavior:** ☐Yes ☐No
☐**Delusions/Hallucinations:** ☐Yes ☐No
☐**Symptoms of depression/anxiety:** ☐Yes ☐No
☐**History of Trauma:** ☐Yes ☐No

☐**Legal Charges/Involvement:** ☐Yes ☐No
☐**Family Issues:** ☐Current ☐Past 12 months
☐**Employment Issues:** ☐Current ☐Past 12 months
☐**Functional Concerns:** (self-care/ hygiene, budgeting/ finances, homemaking, eating/meal preparation, daily activities)
_____
_____
☐**Previous Psychiatric Involvement**
☐**Number of ER Dept. Visits:** ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5+
☐**Chronic Health Diagnosis**
☐**Substance Use (alcohol & drug):** ☐Current Use ☐Past Use
Type Quantity Frequency
_____
_____

PRESENTING PROBLEMS/REASON FOR REFERRAL: _____

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CHILD WELFARE ONLY: (MINOR'S ONLY)

Program Component: ☐ER ☐FM ☐PP ☐Adoptions ☐Voluntary Services ☐EFC ☐LG

Parent/Caregiver: Release to participate: ☐Yes ☐No

Date Opened to CWS: _____ MHST Completed: _____ Releases Attached: ☐Yes ☐No

Has child had 3 or more placements within 24 months due to behavioral concerns? ☐Yes ☐No

OFFICAL USE ONLY

☐Accepted ☐Denied Date Assigned: _____ Assigned to: _____

If NOT eligible: Referral source contacted date: _____

Comments: _____