Mariposa County Behavioral Health and Recovery Services Referral

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 Assessment:** Determine what services are needed

☐ **Substance Use Disorder Services:** Addiction and Substance abuse treatment

☐ Screen for Services

OR

☐ Treatment/Assessment

☐ **Targeted Case Management:** Specialized service population only, contact (209) 742 -0982 for criteria

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CLIENT INFORMATION:

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

Date of Birth: _____ Social Security #: _____ Phone #: _____

Address: _____

Is client homeless or at risk of being homeless? ☐ Yes ☐ No Alt. Phone #: _____

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:

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

Primary Care Physician: ☐ JCF ☐ Comm. Health Centers of America ☐ JCF -Clinic 3 ☐ 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**
Location: _____

☐ **Substance Use (alcohol & drug):** ☐ Current Use ☐ Past Use

☐ **Complex medical issues**

☐ **Probation/Jail**

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: _____