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: _____

MINORS ONLY - Client is currently: ☐At risk for Out-of-Home Placement ☐In Placement ☐N/A

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

Referral For:

- ☐ **Mental Health Assessment (to determine what services are needed)**
- ☐ **Evaluation for Behavioral Health Court**
- ☐ **Substance Use Disorder Services** (Addiction and Substance Abuse Treatment)
  - ☐ Assessment for SUD Services
  - ☐ Evaluation for Level of Care
  - ☐ Evaluation for Drug Court

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: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

CHILD WELFARE ONLY: (MINORS 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: _____