

**Community Referral**

**Request for Services, Please Contact:**

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| Person Making Referral: | | | | | | | | |  | | | | | | | | | | Organization: | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Phone Number: | | | | | |  | | | | | | | | | | | | | Date: | |  | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Client Name: | | | |  | | | | | | | | | | | | DOB: | |  | | | | | | | Sex: | |  | | Age: | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SSN: | |  | | | | | | | | | | Medi-cal ID #: | | | | |  | | | | | | Medi-cal Issue Date: | | | | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Race: |  | | | | | | Ethnicity: | | | | | |  | | State of Birth: | | | |  | | | | Was Client Born in LA County: | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| School: | |  | | | | | | | | Grade: | | | |  | | Parent’s/Guardian’s/Caregiver’s Primary Language: | | | | | | | | | | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Parent/Guardian/Caregiver: | | | | | | | | | | |  | | | | | | Contact #: | | |  | | | | | Alternate #: | | |  | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Relationship to Client: | | | | | | | |  | | | | | | | | Employment Status: | | | | | | Full Time  Part Time  Unemployed | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Marital Status: | | | | |  | | | | | | | | | | | Who has legal custody of the child? | | | | | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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**REASON FOR REFERRAL TO MENTAL HEALTH SERVICES/THERAPY**

**PLEASE CHECK ALL OF THE FOLLOWING THAT APPLY.**

Medical Necessity=Functional Impairment in Home, School or Community

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Depressed/Sad | | Eating issues | Anger outbursts | Grief/loss |
| Irritable | | Sleep issues | Panic attacks | Bullying/threatens others |
| Impulsive | | Inability to focus | Violent/aggressive | Sexualized behaviors |
| Tantrums | | Withdrawn/isolates | Substance abuse | Defiant/oppositional |
| Trauma | | Anxious/worries | Hallucinations | **Self-harm** |
| Sexual abuse | | Hyperactive | Delusions | **Suicidal or homicidal ideation** |
| Comments: |  | | | |
|  | | | | |
|  | | | | |

Minute Order for therapy is needed if dependent of court. Please fax over with referral.

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| --- | --- | --- | --- | --- | --- |
| Current Medications: | |  | | | |
|  | | | | | |
| Allergies: |  | | | | |
|  | | | | | |
| Psychiatric Hospitalizations in Last Year (Dates helpful & reasons): | | | |  | |
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|  | | | | | |
| Has history of, or currently, receiving behavioral/mental health services: | | | | | Yes  No |
|  | | | | | |
| If yes, list provider and briefly explain reason: | | |  | | |

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| --- | --- | --- |
|  |  |  |
| Firma del Padre/Guardian Legal  Parent/Legal/Guardian Signature |  | Fecha  Date |

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