

**Community Referral**

**Request for Services, Please Contact:**

Jackie Gonzales, Mental Health Administrator

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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

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| [ ]  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| [ ]  Tantrums | [ ]  Withdrawn/isolates | [ ]  Substance abuse | [ ]  Defiant/oppositional |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): |       |
|       |
|  |
| 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 LegalParent/Legal/Guardian Signature |  | FechaDate |

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