Service Area: 1☐ 2☐ 3☐ 4☐ 6☐ 7☐

Services preferred at: Home☐ Office☐ School☐

Minute Order/Custody Docs: Yes☐ No☐

Copy Medi-cal/Insurance card: Yes☐ No☐

Referral Support Center

Referral Center Contact : 1(844) 222-2377
Agency Contact: (626) 395-7100
Fax: (323) 837-9719
Email: Referral@hscfs.org

Referring Party:

Referral Date: ______________

Name: ______________________________ Phone: _________________ Agency/Role: ________________________________

Are the client and family aware of this referral? ☐Yes ☐No

Client Information:

Name: ______________________ (M.I.):____ Last Name:______________________ Sex: ☐F ☐M ☐Other DMH ID #: ________

D.O.B:___________________ Age: ______ Race/Ethnicity: _______________ Primary Language: _____________________

Soc. Sec. #:_______________________ Medi-cal: ☐Yes ☐ No If yes, Medi-cal #: _____________________________

School: ____Grade:___________

Bio Mother's Name: _____________________________ Bio Father's Name: _____________________________

Primary Caregiver:

Client currently lives with: ☐Mother ☐Father ☐Guardian ☐Foster Parent ☐Self ☐Other: _________________

Caregiver's Name:_________________________ Primary language:______________________ English Speaker: ☐Yes ☐No

Phone: ____________________________ Alternative Phone: ________________________ Leave message: ☐ Yes ☐No

Address: ____________________________________ City: _____________________________ Zip:_______________

When can we call? Mon☐ Tue☐ Wed☐ Thurs☐ Fri☐ Sat☐ Sun☐ Time:__________________

Clinical Information:

Currently receiving outpatient mental health services? ☐ Yes ☐No ☐ Unknown *If yes, from where/whom?*__________________

Been on psychotropic medication w/in the past 30 days? ☐ Yes ☐No ☐ Unknown Refill date: ______________________

Release from (in the past 7 days): ☐Inpatient ☐Juvenile Hall ☐Jail ☐N/A *Expected release/discharge date?*_________________

If released from inpatient facility, name of facility: ____

Experiencing the following:

☐ Suicidal: Ideation/Intent/Hx ☐ w/in *3 mo. ☐ Homicidal: Ideation/Intent/Hx ☐ w/in *3 mo. ☐ Self-Harm ☐ w/in *3 mo. ***High Risk**	☐Trauma/Abuse/DV/Bullying ☐Hallucinations (Visual/Auditory) ☐Flashbacks ☐Fearfulness ☐Panic attacks ☐Nightmares ☐Anxious	☐Aggression/Destruction of property ☐Disruptive behaviors ☐Defiance/ Non-compliant ☐Difficulties in school ☐Peer problems ☐Difficulty concentrating ☐Impulsive/Hyperactive/Inattentive ☐Temper Tantrums/ Mood changes	☐Depressed/Sadness/Cries Often ☐Isolation/Withdrawn ☐Irritability ☐Bedwetting/Soiling ☐Substance use

Additional Comments/concerns?

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