Referral Type: ☐ Children/Youth ☐ Adults

REFERRAL FORM

Mode of entry: ☐ Phone ☐ Walk-In ☐ Written		**Date of Referral:**	
Legal Last Name:		**Legal First Name:**	
Preferred/Chosen Name (if different than legal)**:**			
SSN:	**DOB:**	**Age:**	**Sex:** ☐ Male ☐ Female ☐ Unknown
Primary Language at Home: ☐ English ☐ Spanish ☐ Hmong ☐ Lao ☐ Other:			
Interpreter Needed? ☐ No ☐ Yes ***If yes, language*:**			
If minor, Parent/Legal Guardian's name:		*(Caregiver(s) name, if different)*:	
Does parent/caregiver need interpreter: ☐ No ☐ Yes			
If minor, is this child in foster care?: ☐ No ☐ Yes, if yes: *Name of Social Worker:*			
Is this a minor consenting to own treatment? ☐ No ☐ Yes		*Is it ok to contact caregiver to schedule appts?* ☐ No ☐ Yes	
Home Address:		**City:**	**ZIP:**
Mailing Address:		*City:*	*ZIP:*
Primary Phone #:	**Alternate Phone #:**		**Ok to leave message:** ☐ Yes ☐ No
What type of appointment reminder do you prefer?	*Please select only one* ☐ Text ☐ Phone Call ☐ None	**Appointment Reminder Phone# (if different than Primary Phone#)**	
Insurance Coverage:	☐ Medi-Cal ☐ Private Insurance	☐ Medicare ☐ Other: ____	☐ None (Self-Pay)
Medi-Cal #:		**Medicare #:**	
Are you currently a CalWORKs recipient? ☐ No ☐ Yes		**AB109** ☐ No ☐ Yes	
Primary Care Physician:		**Phone #:**	
Person Making the Referral: ☐ Self ☐ Parent/Legal Guardian			
☐ Other, *please specify*:			
Reason for Referral *(areas of concern, problems at work, disruptive behavior, etc.)***:**			
Type of services you are interested in:	☐ Counseling Services ☐ Wellness/Group Activities	☐ Psychiatrist/Medication Services ☐ Other, *please specify below*:	
Other:			
Are you having current suicidal/homicidal thoughts? ☐ No ☐ Yes *If yes, please explain*:			

Additional Information: *Please Check All That Apply:*

In the past ***month*** have you experienced?	In the past ***year*** have you experienced?	Do you have any other concerns?
☐ Suicidal plans or intention	☐ Suicidal plans or intention	☐ Difficulty managing emotions, or behaviors such as depression anxiety or anger
☐ Committing an act of violence toward others, or use of force or threats	☐ Committing an act of violence toward others, or use of force or threats	☐ Occasional suicidal thoughts with no plans or intent
☐ A mental health crisis episode/visit	☐ A mental health crisis episode/visit	☐ Other mental health concerns not mentioned
☐ In-patient Psychiatric Hospitalization	☐ In-patient Psychiatric Hospitalization	☐ Other: _____

Glenn County Mental Health **REFERRAL FORM**	**Client Name:**
	Client ID: