Client Meets/Needs Priority Admission Criteria: ☐

Referral Type: ☐ Children/Youth ☐ Adults
Mode of Entry ☐ Phone ☐ Walk-in ☐ Written

REFERRAL FORM

Date of Request:		**Information Taken By:**	
Legal Last Name:		**Legal First Name:**	
Preferred/Chosen Name (if different than legal)**:**			
Social Security Number:	**Date of Birth:**	**Age:**	**Sex:** ☐ Male ☐ Female ☐ Unknown
(If minor, caregiver(s) name):		*Caregiver Primary Language:*	
(If minor, is this child in foster care?: ☐ Yes ☐ No		*Name of Social Worker:*	
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#)	
Primary Language at Home: ☐ English ☐ Spanish ☐ Hmong ☐ Lao ☐ Other:			
Interpreter Needed? ☐ Yes ☐ No ***If yes, language*:**			
Do you have a disability? ☐ Yes ☐ No ***If yes, explain*:**			
Do you have an open Child Welfare Services (CWS) case? ☐ Yes ☐ No		**List ages of children under age 15 in the home:**	
Are you currently a CalWORKs recipient? ☐ Yes ☐ No		**Number in Household** *(on income)***?**	
Are you a Veteran? ☐ Yes ☐ No			
Insurance Coverage: ☐ Medi-Cal ☐ Medicare ☐ Private Insurance ☐ Other: _____ ☐ None(Self-Pay)			
Medi-Cal #:		**Medicare #:**	
Person Making the Referral: ☐ Self ☐ Parent/Legal Guardian ☐ Other, *please specify*:			
Primary Drug/Alcohol Problem:			
Are you currently receiving services for drug and alcohol? ☐ Yes ☐ No *(If Yes, where)*			
Are you currently pregnant? ☐ Yes ☐ No			
Do you have a child aged 1 year or less? ☐ Yes ☐ No			
Have you used alcohol or drugs in the past 30 days? ☐ Yes ☐ No			
Have you used needles to inject drugs in the past 30 days? ☐ Yes ☐ No		**In the past 12 months?** ☐ Yes ☐ No	
Have you been diagnosed with Tuberculosis? ☐ Yes ☐ No			

1a) Have you ever had life-threatening symptoms during withdrawal? ☐ Yes ☐ No

1b) Are you currently having similar withdrawal symptoms? ☐ Yes ☐ No

2) Do you have any current, severe, and untreated physical health problems? ☐ Yes ☐ No

3) Do you feel that you are imminently in danger of harming yourself or someone else? ☐ Yes ☐ No

✸ Yes to question 1a and 1b, and/or 3 requires the caller/client immediately receive medical or psychiatric care.

Glenn County Behavioral Health Substance Use Disorder Services **REFERRAL FORM** Phone: 865-1146 | Fax: 865-6483	**Client Name:** **Client ID:**

CONFIDENTIAL PATIENT INFORMATION (SEE CALIFORNIA WELFARE AND INSTITUTIONS CODE SECTION 5328)