

REFERRAL FOR MENTAL HEALTH/SUBSTANCE ABUSE SERVICES

Walk in Phone Call Agency Referral Date of Referral _____

CLIENT INFO

Last _____ First _____ MI _____ DOB _____ Age _____
 Sex: Male Female SSN#: _____ Language of Choice _____
 Address: _____ Telephone No. _____
 Parent/Guardian _____

REFERRAL SOURCE

Self Agency Name of Referring Agency _____
 SARB SARC Address: _____
 Name of referring person _____ Phone _____
Program referring to: **Mental Health** **Substance Abuse**

REASON AND OBJECTIVE OF REFERRAL

- Is this a Crisis or emergency? Yes No • Is Individual a danger to self or others? Yes No
- Has Individual received MH services in the past? Yes No
- If yes, when and where? _____
- Does Individual take medication? Yes No If Yes, name of medication: _____
- Has the individual used opiates in the last 30 days? Yes No
- Reason for Referral/Other information _____

FINANCIAL RESPONSIBILITY

Does individual have San Benito County Medi-cal? Yes No
 If yes, medi-cal card number _____ (copy of card when available)
 Private Insurance? Yes No If yes, name of insurance _____
 Private Pay Responsible Party _____
 CPS authorized payment Yes No Number of authorized visits _____
 Name of authorized CPS representative _____

OTHER RELEVANT INFORMATION

Other agencies involved, available test results, legal status etc.

RELEASE OF INFORMATION

I, _____ hereby agree to the release of the above information to the San Benito County Behavioral Health Department for the purpose of planning, assessment, and treatment and I further give permission to San Benito county Behavioral Health Services to discuss this referral with the referral source.
 Client: _____ Witness: _____

MGR REVIEWER
(for BH staff only)

Schedule Intake Respond to agency Assigned intake staff _____ Date of appt: _____

SAN BENITO COUNTY BEHAVIORAL HEALTH SERVICES REFERRAL

CLIENT NAME _____
CHART NUMBER _____
DATE: _____