If available, please attach InSyst facesheet, BH Screening Form & any additional clinical info to this referral such as most recent Assessment, Treatment Plan, Psychiatric Evals, hospital intakes/discharge summaries. Please note that a supervisor signature is required in order to process this referral. You should receive a response from ACCESS within two business days of sending. Thank you.

**DEMOGRAPHIC INFORMATION:**

**Date:**

**Client name:**      

**Date of birth:**       **Age:**       **PSP#:**

**SSN:**       **Client phone number:**

**Gender identification, preferred name & pronouns:**

**Address (if homeless include areas where individual spends time):**

**Primary language:**

**Cultural considerations:**

**Does this person have insurance:**  YES  NO

**If yes, what kind?**  Alameda County Medi-Cal  Other County Medi-Cal:

Medi-Medi  Private:

Other:

**REFERRED BY:**

**Person completing form:**

**Phone and email:**

**Relationship to client:**

**Agency/Program (if applicable):**

**Is the individual receptive to this referral for services, please explain if not?**

**REASON FOR REFERRAL:**

**What led to this referral for mental health services:**

**Current mental health needs (include diagnosis(es) and symptoms if possible):**

**How are the mental health issues impacting individual’s functioning:**

**Brief history of mental health needs:**

**If individual is taking psychiatric medications, what medications and who is the prescriber:**

**OTHER RELEVANT INFORMATION:**

**Personal and environmental strengths:**

**Current living situation:**

**Other services person is receiving (provide agency name and type of service):**

**Mental health treatment history (type of treatment, location, provider, dates):**

**Current substance use, substance use history including any treatment:**

**Medical/physical health conditions and considerations:**

**Current safety concerns (within the last 90 days consider suicidality, violence towards others, grave disability, other safety concerns):**

**Past safety concerns:**

**Criminal justice involvement currently and historically:**

**Other relevant information or co-occurring needs:**

**For Court and AFBH Staff only:**

**1370  Adult Forensic Behavioral Health**

**1370.01  Probation**

**Court Advocacy Project  Behavioral Health Court**

**[ ] DSH Diversion [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact person and contact info for the above check marks:**

**How soon is individual expected to be released to jail/returned to community? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is there at court order involved in release? If so, what is timeframe to arrange discharge from jail? \_\_**

**Other information related to criminal justice involvement:**

**Please be sure to include a copy of the Alienist Report, PC Dec, or description of how crimes relate to mental health and risk factors for similar future behavior.**

**TYPES OF SERVICES BEING REQUESTED:**

**Therapy**

**Medication support**

**Clinical care coordination with psychiatry (Level 1)**

**Intensive clinical care coordination with psychiatry (FSP)**

**Outreach in order to engage in services (IHOT)**

**Other (e.g. higher level of care):**

**Supervisor Approval for Request:**

**Supervisor Name:**

**Supervisor Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**

**Send completed form with accompanying materials to ACBH ACCESS:**

Fax: 510-346-1083 or via email to: [ACCESSReferrals@acgov.org](mailto:ACCESSReferrals@acgov.org)

For questions call ACCESS at 1-800-491-9099