Behavioral Health Department
Alameda County Health

TRANSITION AGE YOUTH MENTAL HEALTH SERVICES REFERRAL FORM

Fax completed form to ACBHD ACCESS: (510) 346-1083 OR
via encrypted Email to: ACCESSReferrals@acgov.org
For Questions: Call 1-800-491-9099

IF AVAILABLE, PLEASE ATTACH FACESHEET AND ANY ADDITIONAL CLINICAL INFORMATION TO THIS FORM: MOST RECENT ASSESSMENT & TREATMENT PLAN, PSYCH EVALS, HOSPITAL INTAKES, DISCHARGE NOTES AND ANY OTHER RELEVANT DOCUMENTATION.

REFERRAL DATE:_____

CLIENT NAME:_____ CLIENT PSP #: _____

BIRTH DATE: _____ AGE:_____ GENDER IDENTIFICATION: _____

SSN: _____ CLIENT PHONE NUMBER: _____

ADDRESS: _____

CONTACT PERSON & PHONE NUMBER: (IF NOT CLIENT):_____

CULTURAL & LANGUAGE CONSIDERATIONS: _____

_____

DOES THE CLIENT HAVE INSURANCE? ☐ YES ☐ NO

IF SO, WHAT KIND? ☐ ALAMEDA COUNTY MEDI-CAL ☐ OTHER COUNTY MEDI-CAL: _____

☐ PRIVATE: _____ ☐ OTHER:_____

*Please note: If client has private insurance only, client is not eligible for mental health services through Alameda County Behavioral Health Department. Call client's private managed care plan for services.

REFERRED BY

YOUR NAME: _____RELATIONSHIP TO CLIENT:_____

AGENCY (IF APPLICABLE): _____

PHONE: _____EMAIL: _____

MANDATORY FOR FSP REFERRALS, SUPERVISOR SIGNATURE: _____

IS CLIENT AWARE OF AND/OR RECEPTIVE TO REFERRAL? ☐ YES ☐ NO ☐ AMBIVALENT

WHO IS BEST PERSON TO FACILITATE FIRST CONTACT WITH CLIENT?
PROVIDE NAME, RELATIONSHIP TO CLIENT AND CONTACT INFORMATION:

Behavioral Health Department
Alameda County Health

REASON FOR REFERRING:

CURRENT DIAGNOSIS & SUPPORTING SYMPTOMS- DSM 5 DESCRIPTION WITH ALL SPECIFIERS, IF AVAILABLE:

LIST CURRENT MEDICATION & COMPLIANCE:

PRESCRIBING MD: _____ NEXT APPOINTMENT DATE: _____

MEDICATION HISTORY, IF AVAILABLE:

MEDICAL/PHYSICAL HEALTH CONSIDERATIONS:

HOSPITALIZATION HISTORY (ONLY IF NOT AVAILABLE ON FACESHEET):

SELF-HARM/SERIOUS ATTEMPTS HISTORY:

SUBSTANCE ABUSE (DRUG OF CHOICE? HOW LONG? FAMILY HISTORY?):

CRIMINAL/VIOLENCE HISTORY:

TRAUMA HISTORY:

HAS THE CLIENT BEEN IN FOSTER CARE? ☐ YES ☐ NO

JURISDICTION: _____ CWW:_____

CWW PHONE#: _____ CWW EMAIL:_____

PLEASE DESCRIBE THE CLIENT'S FOSTER CARE CIRCUMSTANCES & EXPERIENCE:

STRENGTHS, SOCIAL SUPPORTS & FAMILY INVOLVEMENT:

EDUCATION: GRADE COMPLETED_____ ☐ HIGH SCHOOL DIPLOMA ☐ GED ☐ COLLEGE DEGREE
☐ CERTIFICATE OF COMPLETION ☐ OTHER CERTIFICATIONS/TRAINING: _____

WHAT ARE CLIENT'S EDUCATIONAL, VOCATIONAL AND/OR CAREER GOALS?

CURRENT LEVEL OF SOCIAL/INTELLECTUAL FUNCTIONING & DAILY LIVING SKILLS:

STATUS OF BENEFITS & APPLICATION FOR ADULT SSI:

CURRENT LIVING SITUATION (IF ENDING, WHY & WHEN? WHERE WILL CLIENT LIVE IN NEXT 6 MONTHS?):

WHAT HAS BEEN DONE TO HELP TRANSITION CLIENT TO ADULT MENTAL HEALTH SERVICES?

WHAT AGENCIES & OTHER RESOURCES ARE INVOLVED?

☐ THPP/ THP+: _____ ☐ CASE MGMT: _____

☐ HOUSING: _____ ☐ MENTAL HEALTH: _____

☐ OTHER: _____

WHAT DOES THE CLIENT WANT AND/OR NEED:

☐ MH SERVICES ☐ MEDICATION SUPPORT ☐ CASE MANAGEMENT ☐ VOCATIONAL SUPPORT

☐ HOUSING ☐ TO CONTINUE EDUCATION ☐ 1ST EPISODE PSYCHOSIS W/IN 2 YEARS

☐ OTHER: _____

WHAT IS THE CURRENT DISCHARGE PLAN?