alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ADULT OUTPATIENT MENTAL HEALTH SERVICES REFERRAL FORM

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:

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

Primary language:

Other 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:

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Brief history of mental health needs:

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

<u>OTHER RELEVANT INFORMATION:</u>

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):

Substance use history including any substance use 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:

For Court and AFBH Staff only:

- ☐ **1370**
- ☐ **1370.01**
- ☐ **Court Advocacy Project**
- ☐ **Adult Forensic Behavioral Health**
- ☐ **Probation**
- ☐ **Behavioral Health Court**

Contact person and contact info for the above check marks:

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

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TYPES OF SERVICES BEING REQUESTED:

- ☐ **Therapy services**
- ☐ **Psychiatric medication management**
- ☐ **Clinical care coordination with psychiatry**
- ☐ **Intensive clinical care coordination with psychiatry**
- ☐ **Outreach in order to engage in services**
- ☐ **Other:**

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

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