alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

TRANSITION AGE YOUTH MENTAL HEALTH SERVICES REFERRAL FORM

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

IF AVAILABLE, PLEASE ATTACH INSYST 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. THANK YOU.

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 specialty mental health services through Alameda County Behavioral Health. 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:

_____

_____

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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 INSYST FACESHEET): _____

_____

_____

SELF-HARM/SERIOUS ATTEMPTS HISTORY: _____

_____

_____

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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? _____

_____

_____

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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?

☐ THP/ THP+: _____ ☐ CASE MGMT: _____

☐ HOUSING: _____ ☐ MENTAL HEALTH: _____

☐ OTHER: _____

WHAT DOES THE CLIENT WANT AND/OR NEED:

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

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

☐ OTHER: _____

WHAT IS THE CURRENT DISCHARGE PLAN?_____

_____

_____

_____