

## TRANSITION AGE YOUTH MENTAL HEALTH SERVICES REFERRAL FORM

Fax completed form to ACBH ACCESS: (510) 346-1083 OR Via Secure Email to: <a href="mailto:ACCESSReferrals@acgov.org">ACCESSReferrals@acgov.org</a>

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:                                    |                    |  |
| BIRTH DATE:                                     | AGE:               | GENDER IDENTIFICATION:   |
| SSN:  | CLIENT PHO         | NE NUMBER:   |
| ADDRESS:  |                    |  |
| CONTACT PERSON & PHONE                          | NUMBER: (IF NOT C  | LIENT):  |
| CULTURAL & LANGUAGE CO                          | NSIDERATIONS:      |  |
| DOES THE CLIENT HAVE INS                        | SURANCE?   YES     | □NO  |
| IF SO, WHAT KIND? ☐ ALAM                        | EDA COUNTY MEDI-   | CAL  OTHER COUNTY MEDI-CAL:  |
| PRIVATE:  |                    | OTHER:   |
|   |                    | nt is not eligible for specialty mental health services nt's private managed care plan for services. |
| REFERRED BY                                     |                    |  |
| YOUR NAME:                                      |                    | RELATIONSHIP TO CLIENT:  |
| AGENCY (IF APPLICABLE): _                       |                    |  |
| PHONE:  |                    | EMAIL:   |
| MANDATORY FOR FSP REFE                          | RRALS, SUPERVISOF  | R SIGNATURE:   |
| IS CLIENT AWARE OF AND/O                        | R RECEPTIVE TO REF | FERRAL? YES NO AMBIVALENT  |
| WHO IS BEST PERSON TO<br>PROVIDE NAME, RELATION |                    | CONTACT WITH CLIENT?<br>ND CONTACT INFORMATION:  |
|   |                    |  |



| REASON FOR REFERRING:   |
|---|
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|   |
| 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:   |
|   |
|   |



| SUBSTANCE ABUSE (DRUG OF CHOICE? HOW LONG? FAMILY HISTORY?):   |
|--|
| CRIMINAL/VIOLENCE HISTORY:   |
| TRAUMA HISTORY:  |
| HAS THE CLIENT BEEN IN FOSTER CARE?  |
| 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?  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   1 <sup>ST</sup> EPISODE PSYCHOSIS W/IN 2 YEARS   OTHER: |
|  |