Reset Form Print Form

HealthPAC
Health Program of Alameda County
Primary Care (PC) to Specialty Behavioral Health (BH) Referral Form

Fax this referral to ACCESS at (510) 346-1083
Include the HealthPAC Initial Risk Assessment and any other supporting documents

Patient Name: _____

Primary Language: _____

Date of Referral: _____ HealthPAC ID#: _____

Patient Date of Birth: _____ Clinic ID or MR#: _____

Referral to: Alameda County Behavioral Health Care Services - ACCESS
Phone: (800) 491-9099
Fax: **(510) 346-1083**

Referral Source**:**

Provider Name: _____

Provider Title/Role: _____

Referring Clinic Name: _____

Referring Clinic Address (must include): _____

Contact Phone: _____

Fax # (required): _____

Purpose of Referral (medication, therapy, etc.):

ACCESS Final Disposition:

Referred to: _____

Phone Number: _____ Fax Number: _____

Type of Service: _____ Level: _____

Number of Sessions Authorized: _____

_____ _____ _____

Name of Staff Making Referral (Print) Date Phone Number

HealthPAC
Health Program of Alameda County

Patient Name: _____

HealthPAC Initial Risk Assessment (to be completed face to face)

1. Date of assessment: _____

2. Demographics/Patient Contact Information:

Social Security #: _____ ☐ Male ☐ Female ☐ Transgender

Address: _____ City: _____ Zip: _____

Tel: _____ Marital Status: _____ Highest Educational Grade completed: _____

Ethnicity/Race: _____ Hispanic Origin: _____

Birthplace: _____ Birth Last Name: _____ Mother's First Name: _____

Preferred Language: _____ Physical Disability: _____

3. Presenting Behavioral Problems (check all that apply and/or describe below):

- ☐ Adjustment to trauma/major stressors, separation, loss, death, job, school
- ☐ Anger Control
- ☐ Anxiety, fear, panic, agitation
- ☐ Depression, hopelessness
- ☐ Eating Disturbance
- ☐ Employment/School functioning problems
- ☐ Family relationship problems
- ☐ Hyperactivity
- ☐ Impulse control problems
- ☐ Mania, elevated mood
- ☐ Pain without clear medical explanation
- ☐ Psychosis, unreal thoughts or beliefs, auditory and/or visual hallucinations
- ☐ Residential instability/Risk of homelessness
- ☐ Sleep Disturbance
- ☐ Substance abuse/dependence
- ☐ Victim of abuse, physical, sexual and/or severe neglect
- ☐ Other, describe below

DESCRIBE ONSET, DURATION, AND SEVERITY OF SYMPTOMS/IMPAIRMENTS, INCLUDING RELEVANT HISTORY AND SIGNIFICANT LIFE EVENTS:

4. Risk Assessment (check appropriate rating)

Danger to self	☐ None	☐ History but no recent intent, ideation or feasible plan	☐ Recent ideation, no current feasible plan	☐ Recent ideation, intention, plan that is feasible and/or history of a potentially lethal attempt	☐ Current ideation or command hallucinations re self-harm, current intent, plan that is immediately accessible and feasible, and/or history of multiple potentially lethal attempts. **Call 911 IMMEDIATELY.**
Danger to others	☐ None	☐ History but no recent gesture or ideation	☐ Recent ideation, no current feasible plan	☐ Recent homicidal ideation, physically harmful aggression or dangerous fire setting, but not in past 24 hours. Has feasible plan to harm others	☐ Acute homicidal ideation with an accessible, feasible plan of physically harmful aggression, or command hallucinations involving harm of others. Or intentionally set fire that placed others at significant risk of harm. **Call 911 IMMEDIATELY.**

Name: _____

HealthPAC Initial Risk Assessment (to be completed face to face)

4A. Other Risk Factors (if yes, please describe below:) ◯ No ◯ Yes

4B. Previous Psychiatric Hospitalization ◯ No ◯ Yes Date/reason of last hosp: _____

4C. Risk Assessment (ELABORATION OF ALL RISK FACTORS)

5. Current Mental Status

Mood	☐ Depressed	☐ Anxious	☐ Euphoric	☐ Other
Affect	☐ Appropriate	☐ Inappropriate		
Thought process/content	☐ Normal	☐ Loose/Tangential	☐ Grandiose	☐ Paranoid
Hallucinations	☐ Auditory	☐ Visual	☐ Other	
Orientation	☐ Time	☐ Person	☐ Place	
Cognitive	☐ Memory problem	☐ Lack of insight	☐ Poor judment	☐ Concrete thinking

Mental Status Comments:

6. Substance Use Concerns (Describe screening done, current, and past use, and impact of use):

Name: _____

HealthPAC Initial Risk Assessment (to be completed face to face)

7. Legal Issues	Court Mandated Treatment ◯ No ◯ Yes	Probation/Parole: ◯ No ◯ Yes	History of arrest: ◯ No ◯ Yes	
8. Mental Health	Currently receiving services ◯ No ◯ Yes If yes, where:	Conserved ◯ No ◯ Yes	History of treatment ◯ No ◯ Yes	Current psych meds ◯ No ◯ Yes If yes, add to medication list

9. Primary Care working mental health diagnos(es):	

10. Additional Comments (describe functional impairments, primary care treatment attempts, and response, other factors):	

Please answer #11 and #12 below OR provide other documents listing current medications and health conditions:

11. Current Medications *(include all behavioral and physical meds)*

Med Allergies: _____

Medication Name	Strength	Frequency	Purpose	Prescriber

12. Patient's other health conditions:	

Staff Name (print): _____

_____ _____

Clinician/Staff/Other Appropriate Signature Date: