

Referral Request for Presumptive Transfer Child in San Mateo County (AB1299)

“Confidential Patient Information: See California Welfare and Institutions Code Section 5328”

Date of Request:	
Child's Name:	
Date of Birth:	SSN or CIN:
Language:	Ethnicity:

Placement/Caregiver's Name:
Address:
Phone:

Placing Agency:	County:
Child Welfare Worker (CWW) Name:	
CWW Phone:	CWW Fax:
Probation Officer name and contact information if applicable:	

Name and contact information of who can sign Release of Information:

Name and contact information of who can sign Consent to Treat:

Is child on prescribed psychotropic medication? Yes ____ No ____ (If YES, please include the current JV220)
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Presenting behaviors/concerns:

Currently in Mental Health Treatment? Yes _____ No _____
If YES, please include names and contact information of service providers:
If recent mental health records are available (most recent mental health assessment, treatment plan, or mental health screening tool) please submit with this request.

To ensure that SMHS are provided in accordance with any existing court orders issued in your county, please provide the following (please attach):
The language from any court orders that specify the mental health services to be provided to the child:
The next court hearing date for the child:
The name and contact information for the child's attorney:

Requested by (Printed Name): _____ **Date:** _____

Signature: _____ **Phone Number:** _____

If you have any questions about the information we need you to provide, please send an email to KKang@smcgov.org and someone will respond.

San Mateo County BHRS Tracking Use Only

Date Referral Request Received: _____

Name of Provider Child is Referred to: _____

Date Referral Sent to Provider: _____

Notes: _____

Processed by: _____