San Mateo County Health
Behavioral Health & Recovery Services,
Adult & Older Adult Community Program Referral Form
(All Sections of the Referral Must Be Completed)

(Place a check next to the program to which you are referring your client)

CAMINAR:	☐ HAWTHORNE HOUSE	☐ EUCALYPTUS HOUSE	☐ NEW VENTURES
	☐ REACH	☐ REDWOOD HOUSE	☐ YAIL
MATEO INC:	☐ CASSIA	☐ HUMBOLDT	☐ WALLY'S
TELECARE:	☐ CORDILLERAS SUITES	☐ CORDILLERAS MHRC	☐ BOARD & CARE
FSP:	☐ FSP	☐ PROVIDER BASED ASSISTANCE VOUCHERS (PBA)	

DEMOGRAPHICS:

Client Name: _____ Referral Date: _____ Admit Date of Current Placement: _____

Mental Health Number (MIS): _____ Birth Date: _____ Age: _____ Gender: **Please Select**

Soc. Sec. Number: _____ Race: _____ Ethnicity: _____

Language: _____ Secondary Lang: _____ Primary Religious Pref.: _____

Last Year of School Completed: _____ Marital Status: **Please Select**

Current Placment Info: Name of Facility, Address, Phone# (if applicable):

* If hospitalized, can client return to above address: ☐ Yes ☐ No

Legal Status: Select All if Apply:

Please Select

Conservator/Phone#: _____

Please Select

PO/Parole Officer/Phone#: _____

Please Select

Please Describe:

Other Legal Status: Select All if Apply:

Please Select

Please Select

Please Select

Is client a veteran? **Please Select** Receive VA Services? **Please Select**

Is client a GGRC client? **Please Select**

Reason for Referral (*Please specify why the client is in need of the type of program you have selected above***)**:

What does the client want in terms of housing, and what supports does the client feel they need to support their transition to a community level placement?

Is there an existing housing plan and include how the placement will be paid for (please be specific).

DIAGNOSTIC DATA: Enter Code and Name: (for multiple dx separate with semicolon)

Primary Diagnosis:

Additional Diagnosis:

Axis III:

Emergency Contact: Name/Address/Phone#/Relationship:

FAMILY/SUPPORTS (*as identified by the client)*

Name/Relationship:

Address/Phone Number:

Name/Relationship:

Address/Phone Number:

TREATMENT TEAM (Please indicate N/A or Unknown)

Treatment Team Name: Select All if Apply

Please Select Name/Ph#:

Please Select Name/Ph#:

Please Select Name/Ph#:

Please Select Name/Ph#:

Other (Provider/Title): **Phone #:**

PSYCHIATRIC DATA:

BRIEF PSYCHIATRIC HISTORY

Client meets criteria for FSP due to one or more of the following: **Please Select**

2 psychiatric inpatient hospitalizations within the past 6 months: **Please Select**

Most recent hospitalization was within the past 30 days: **Please Select**

3 ED/PES visits within the past 60 days: **Please Select**

Date of most recent hospitalizations/hospital:

Describe reason for hospitalization:

Describe baseline functioning:

Describe current functioning level:

Please Select

Suicide Attempts: **Please Select**

Date of most recent attempt:

If yes, please describe:

History of violence (homicidal/assaults/sexual assault/arson/property destruction): **Please Select**

Date of most recent incident: History of Multiple Incidents: **Please Select**

Please describe behavior:

Drug or alcohol use/abuse: **Please Select**

If yes, types (Nicotine, prescription, drug, alch, etc):

If yes, has there been any treatment and where:

Client Stage of Change: **Please Select**

History of Eating Disorder: **Please Select**

If yes, please describes:

If yes, please provide the following treatment facility and dates of treatment

Client Stage of Change: **Please Select**

History of trauma: **Please Select**

If yes, please describes:

If yes, Date(s) of treatment: Treatment facility:

RESPONSE TO MEDICATIONS

Response to medications: Symptoms are: **Please Select**

If persistent, please describe:

Medication compliance: **Please Select**

If no, describes:

Stage of Change: **Please Select**

Able to take meds independently: **Please Select**

Med seeking behaviors: **Please Select**

If yes, describes:

MEDICAL DATA: **Please Select**

☐ Diabetes, if yes: **Please Select**

Ambulatory: **Please Select**

Describe if assistive devices is required: **Please Select**

Allergies: **Please Select**

If yes, list:

☐ Special dietary requirements Describe:

Please list any additional pertinent medical issues:

Treatment required for above medical issues:

CLIENT STRENGTHS

Coping Skills: Please Describe:

Please Select

Please Select

Please Select

Client Strengths:

Social Support: ☐ Family ☐ Peer ☐ Cultural ☐ Church Group ☐ Recovery

☐ Other (Describe):

Day Activities (describe):

Vocational history and current work status**:**

Community referrals in progress: (VRS, School, Support Emp., Club House, 12-step, Senior Center, etc)
Please describe:

FINANCIAL INFORMATION

Gross monthly income: Eligible for Benefits: ☐ Yes ☐ No ■ Unknown

If not eligible describe why:

Source of income: **Please Select**

Is client under Rep. Payee? ☐ Yes ☐ No ☐ Pending

If yes, who? Ph:

Is SSI Pending? ☐ Yes ☐ No ☐ N/A

If yes, Date of Application:

MediCal # ☐ Pending ☐ Yes ☐ No

If Pending Contact Person(s):

MediCare # ☐ Pending ☐ Yes ☐ No ☐ Other Insurance:

If Pending Contact Person(s):

Functional Assessment

Personal Hygiene: **Please Select**

Handling Money: **Please Select**

Literacy: **Please Select**

Use of public transportation: **Please Select**

Appointments: **Please Select**

Involvement in Social Activities: **Please Select**

Cooking: **Please Select**

Housekeeping: **Please Select**

For referrals to temporary housing facilities, what is the future housing plan?

Name/Title of individual making referral: **Signature:**

Region/Program: **Phone #:**

Signature of Supervisor/Unit Chief: **Date:**

Medication List

Please list all MEDICAL MEDICATIONS: (Or attach complete med list)

Medications, Strength and Instruction: Prescribed by:

1.
2.
3.
4.
5.
6.

Last Appt Date: _____ Next Scheduled Appt. Date: _____

*** *Redwood House and Social Rehabs Require Physician's Signature on Med list****

Physician Name: _____ **Phone#:** _____

Physician Signature: _____ **Date:** _____

Please list all PS MEDICATIONS: (Or attach complete med list)

Medications, Strength and Instruction: Prescribed by:

1.
2.
3.
4.
5.
6.

Last Appt. Date: _____ Next Scheduled Appt. Date: _____

*** Redwood House and Social Rehabs Require Physician's Signature on Med list***

Psychiatrist Name: _____ **Phone#:** _____

Psychiatrist Signature: _____ **Date:** _____