SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

SPPN REFERRALS
ONLY FOR SMI ADULTS
Email to: HS_BHRS_Call_Center_PPNReferrals_Internal@smcgov.org

Name of Care Coordinator:	**Phone:**
Name of Client:	**DOB**:
Preferred Name:	**MHN:**
Primary Diagnosis Code (ICD10): ***ICD-10 must match most recent assessment***	
Client's Phone #: **Ok to leave detailed message:** ✓ **Yes** ☐ **No** **Email:** _____ **Preferred Language:** _____	**SPPN <u>does not accept</u>** Medicare Noridian only, ACE, Restricted MediCal, private insurance & no insurance. ***Please attach proof of insurance (HPSM Trio and Meds Lite)***
	Insurance Verified: ☐ **Yes** ☐ **No**
	Insurance type:
	Medi-Cal CIN or HSN #:
	Date checked:
Brief Demographic (Age, Gender, location, etc.):	
Focus of treatment:	
Presenting issues:	
Safety Plan:	
Current risk of harm to self: ☐ **Yes** ☐ **No**	**Current substance use:** ☐ **Yes** ☐ **No**
Current risk of harm to others: ☐ **Yes** ☐ **No**	
Treatment Readiness for Psychotherapy: Please check each box ☐ Match to Group Practice only (Agency) ☐ Psychotherapy is recommended and client has been assessed as treatment-ready (See detail in Progress note dated _____)	**Preferences – Please specify:** ☐ Therapist Gender: _____ ☐ Location: _____ ☐ ADA accommodations: _____ ☐ Language: _____ ☐ Other: _____ **Is client flexible about preferences:** ☐ **Yes** ☐ **No**
Reason for referral (check one): ☐ Clinic at Capacity ☐ Specialty Care ☐ Other: _____	**Specialties preferred:** _____ *Specialties are for client preference. Referral depends on provider availability and expertise. Often the SPPN, may not have an available provider with that specialty. *

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

SPPN REFERRALS
ONLY FOR SMI ADULTS
Email to: HS_BHRS_Call_Center_PPNReferrals_Internal@smcgov.org

Name of Client: _____ **MHN:** _____

Active Treatment Plan Start Date: _____ **End Date:** _____

Treatment Plan must include all interventions including check boxes that the SPPN provider will be providing (individual therapy, Family Therapy, Collateral, Case Management)

Intervention	Frequency (1 x Weekly, etc.)
Individual Therapy – (OPPSY)	_____ X ☐ Weekly _____ X ☐ Every other week _____ X ☐ Monthly _____ X ☐ Other or N/A _____
Family Therapy - (Family Therapy Associated)	_____ X ☐ Weekly _____ X ☐ Every other week _____ X ☐ Monthly _____ X ☐ Other or N/A _____
Collateral - *Contact with one or more family members and/or significant support persons* **(90887)**	_____ X ☐ Weekly _____ X ☐ Every other week _____ X ☐ Monthly _____ X ☐ Other or N/A _____
Case Management - *This code needs to be included in every treatment plan for collaborative consultation with the treatment team. (SPPN providers do not provide case management services to the client.)* ***(T1017)***	_____ X ☐ Weekly _____ X ☐ Every other week _____ X ☐ Monthly _____ X ☐ Other _____

Supervisor Signature: _____

Printed Name: _____