



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)

Presenting behaviors/concerns:



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

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

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 HS_PTInfo@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: _____