Behavioral Health Services Referral

460 Kings County Dr. Suite 101
Phone Number: (559) 852-2444 Fax: (559) 589-6928
Email: bhinfo@countyofkings.com

Date of referral: ______________

Name of client: ______________________________ **DOB**:__________ **Age**: __________

Gender assignment at birth: Male Female Decline

Current Gender Identity: Male Female Transgender Other **Does client identify as LGBTQ?** ☐ Yes ☐ No

Ethnicity: ______________________________ **Race**: ______________________________

Veteran: ☐ Yes ☐ No

Any known disabilities: ☐Yes ☐No ☐Unknown

Home Address: ______________________________ **City**: __________ **ZIP**: __________

Mailing Address: ______________________________ **City**: __________ **ZIP**: __________

Phone: (Home)__________________ (Cell)__________________ (Mess) __________________

May we contact by: ☐ Mail ☐ Phone

Parent/Guardian (if minor):______________________________

If minor, can parent be contacted? ☐ Yes ☐ No

Interpreter Needed? ☐ Yes ☐ No

Does the client have Medi-Cal? ☐ Yes ☐ No

Does the client have private insurance? ☐ Yes ☐ No

Does client have an open CWS case? Yes No

Primary language: ______________________________

If yes, have they been referred to Kings View? ☐ Yes ☐ No

If yes, were they referred to outside provider? ☐ Yes ☐ No

REFERRAL FOR THE FOLLOWING SERVICES:

Children's System of Care (CSOC):

- ☐ **Individual Counseling:**
- ☐ **Parent Child Interactive Therapy (PCIT)(2-7 y/o)**
- ☐ **Skill Building Groups**
  Name of School: ______________________________
- ☐ **Lifesteps (SARB Board Only)**

Adult System of Care (ASOC):

- ☐ **Individual Counseling:**
- ☐ **Collaborative Justice Treatment Court (Court/Probation Only)**
- ☐ **Veteran Support Group**

Is the client currently receiving Mental Health Services? ☐**Yes** ☐**No** **Diagnosis**__________**By Whom**__________

Did the client receive Mental Health Services in the past? ☐**Yes** ☐**No** **Diagnosis**__________**By Whom**__________

When__________

What recent changes have you noticed in the client?

☐ Changes in affects (moods/personality) ☐ Conflict resolution style ☐ School attendance
☐ School performance ☐ Social interactions ☐ Other: ______________________________

Has the client recently experienced:

☐ Being Bullied ☐ Change in family dynamics – what changed? __________________ ☐ CPS/Foster Care
☐ Justice system involvement: When/Why? __________________ ☐ Loss of a loved one: Who/When? __________________
☐ Physical/sexual abuse ☐ Other: ______________________________

What kind of behaviors is the client currently displaying?

☐ Experimenting with alcohol and/or drugs ☐ Having suicidal thoughts ☐ Isolation or withdrawn
☐ Lack of interest in things they used to enjoy ☐ Previous suicide attempts When? __________
☐ Risky behavior Examples: __________________ ☐ Sadness/depression
☐ Self harm Examples: __________________ ☐ Uncharacteristic aggression

Other: ______________________________

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Please provide more details for any of the above categories: ______________________________

____

____

____

Referring Agency/Party: ______________ Referring Name: ______________

Phone: ______________ FAX: ______________

Reason for referral: ______________________________

____

Referring party signature: ______________ Date: ______________

BH USE ONLY:

BH Services:

☐ Individual Counseling
☐ PCIT (2-7 years of age)
☐ School Skill Building Groups: ______________
☐ Groups
☐ Lifesteps
☐ CJTC/Court Date: ______________

☐ **Information Only, No referrals made, Date:**________

Does client have a disability: ☐ Yes ☐ No
☐ Developmental ☐ Physical ☐ Decline to State

☐ **Linkages: Other Agency**
Referral made to:______________**I & R Date:** ______
Program referred to:______________

Agency Name______________**Date:**______________

Agency Name______________**Date:**______________

Agency Name______________**Date:**______________

Date Case Rec'd/Opened:__________**Assigned to:**______________**Anasazi Number:** ______________