sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

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# Sonoma County Mental Health Youth Access Service Request

Instructions: List one client per form. Fax form to Youth Access 707-565-5290 .

**Youth Access Main Line: 707-565-4729 Youth Access Fax Number:707-565-5290**

**Date of Referral:**_____ **Submitting Agency:**_____

**Contact Name:**_____ **Contact Number:**_____

**Relationship to Client:**_____

**Client Name:**_____ **Client DOB:**_____

**Gender:** ☐Male ☐Female ☐Other:_____ **Foster Youth:** ☐Yes ☐No **Adopted:** ☐Yes ☐No

**Client Language:** ☐English ☐Spanish ☐Bilingual ☐Other:_____

**Current Sonoma County MediCal Number:**_____ **Active:** ■Yes ☐No

**Legal Guardian Name:** _____
**Legal Guardian Number:** _____ ☐ **VM** ☐**Txt**
**Legal Guardian Language:** ☐English ☐Spanish ☐Bilingual ☐Other _____
**Legal Guardian Address:** _____
**Legal Guardian Email Address:** _____

**Legal Guardian able to make Medical decisions for client? ■ Yes ☐ No**
**If no, who is?** _____ **Relationship to Client:** _____
**Phone Number:** _____ **Email Address:** _____

**Presenting Problems (check all that apply):**

☐ Abuse ☐ Attention-Deficit ☐ Anxiety ☐ Appetite Problems ☐ Chronic Pain ☐ Defiant/Oppositional

☐ Delusions ☐ Depressed Mood ☐ Developmental Issues ☐ Disorganized Thoughts ☐ Does Not Bond

☐ Enuresis/Encopresis ☐ Fire Setting ☐ Frequent Nightmares ☐ Grandiosity ☐ Hallucinations ☐Hyperactivity

☐ Inappropriate Sexual Behavior ☐ Irritability ☐ Obsessive-Compulsive ☐ Paranoia ☐ Poor Concentration

☐ Sleep Difficulty ☐ Tantrums ☐ Trauma ☐ Victimizes Others ☐ Withdrawn

**Risk Factors (check all that apply):**

☐ Current Suicidal Ideation ☐ History of Suicidal Ideation ☐ History of Suicide Attempts
☐ Current Homicidal Ideation ☐ History of Homicidal Ideation
☐ Current Self-injurious Behaviors ☐ History of Self-injurious Behaviors
☐ Homelessness ☐ History of Psychiatric Hospitalizations

**Primary Care Physician Name:**_____ **Facility:**_____
**Psychiatrist Name:**_____
**Current Medications:**_____
**Prescribed By:**_____ **Phone Number:**_____

**Comments Regarding Current Presenting Problems/Risk Factors:**

**Comments Regarding Psychiatric history/Treatment history/Dates of Hospitalizations**

**Additional Information: (other agencies involved ie: CPS/Probation/NBRC/ELI/etc, medical issues, cultural issues, transportation issues, etc...)**

**Services Being Requested:**

**Parent/Legal Guardian Aware that Referral was Sent to Sonoma County Behavioral Health? ☐ Yes ☐ No**

**If No, Explain:**

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