ChildNet
Youth and Family Services

Behavioral Health Services Referral

5150 E. Pacific Coast Hwy. Suite 100 Long Beach, CA 90804 Phone 562.490.7600 Fax 562.997.4450

Name

_____
FIRST MIDDLE LAST

Returning Client? Yes_____ No_____

Referral Source

_____

Medi-Cal # _____
Issue Date _____

Social Security # _____-_____-_____

MIS # _____

Age _____

_____ /_____ /_____
Date of Birth

Gender: Female ____ Male ____

Ethnicity

_____

Language other than English? If yes complete:

Client language: _____

Caregiver language: _____

Translator needed? YES_____ NO_____

Address

_____
Street Number Street Name Apt./Unit #

_____
City State Zip Code

Phone # _____

Other # _____

Caretaker Name _____

Relationship to Child _____

Referring Person Name _____

Referring Person Phone number _____

Relationship to Child _____

Reason for Referral

__Danger to self-S/I	__Violent	__Anxious	__Overactive	__Peer problems	__Hallucinations	__Eating issues
__Danger to others-H/I	__Depressed/sad	__Fearful	__Easily distracted	__Substance use	__Delusions	__Grief issues
__Defiant	__Cries often	__Nightmares	__Impulsive	__Panic attacks	__Bizarre behavior	__Recent move
__Aggressive	__Withdrawn	__Bedwetting	__School difficulty	__Compulsions	__Sleep issues	__abuse/neglect
__Court ordered	__Foster care	__Social phobia	__Other_____			

_____
_____
_____
_____
_____
_____
_____

Complete if Ward/Dependant of court

Attorney _____
phone_____

CSW/DPO_____
phone_____

FFN Worker_____
phone_____

Minute Order? Yes _____ No_____

School _____

School Phone # _____ Grade _____

Therapist preference _____

Previous Mental Health Services?

No _____

Yes _____ Where? _____

BHS Clinician currently in Home?

No_____

Yes _____

Name _____

BHS USE ONLY

Taken by:_____ Date assigned:____/____/____

Date Received: ____/_____/____ Clinician:_____

Urgency Scale: 1 2 3

Intake Clinician

_____

___Enroll

___Assessment