Behavioral Health Services Referral

3545 Long Beach Blvd., Long Beach, CA 90807 Phone 562.490.7600 Fax 562.997.4450

Client Information

Name

First _____ Middle _____ Last _____

Address _____
Street Number _____ Street Name _____ Apt/Unit # _____

City _____ State _____ Zip Code _____

Phone # _____ Email _____

Age _____
Date of Birth _____
Sex _____
Client self identifies as _____
Ethnicity _____
Language _____

Medi-Cal # _____
Issue Date _____
Social Security # _____
ID/MIS # _____
Medical Card Sex ☐ M ☐ F

School _____
Grade _____
School Phone # _____
Does child have an IEP? ☐ YES ☐ NO

Caregiver Name _____
Relationship to Child _____
Caregiver Phone # _____
Caregiver Language _____

Date Completed _____
Referring Person Name _____
Relationship to Child _____
Referring Person Phone # _____
Referring Agency/School Name _____

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☐ Aggressive	☐ Withdrawn	☐ Bedwetting	☐ School difficulty	☐ Compulsions	☐ Sleep issues	☐ Abuse/neglect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	☐ Intellectual disability	☐ Pervasive developmental disorder/Autism		☐ Other _____

Attorney _____ Phone _____

CSW/DPO _____ Phone _____

FFN Worker _____ Phone _____

*Please attach minute order or court order if available

Previous Mental Health Services? ☐ YES ☐ NO Where? _____

Previous ChildNet client? ☐ YES ☐ NO

Therapist preference _____

BHS Clinician currently in Home? ☐ YES ☐ NO

Name _____

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Do Not Complete

---------- ChildNet Staff Only ----------

History

Does client have existing medical conditions? _____

Does client have known developmental delays? _____

If yes, does client have Regional Center services? _____

Has client been released from a psychiatric hospital, jail/juvenile hall, or residential facility within the past 7 days? _____

Details if 'yes' _____

Does client have any history or psychiatric hospitalization? _____

If 'yes,' when? _____

Where? _____

Notes

Medications

List names of current medications _____

Is client compliant with meds? ☐ YES ☐ NO

If currently on psychiatric medications, how long is the supply good for? _____

Risk & Safety Factors

Check any area below that presents a current issue in the client's health and safety

- ☐ Probation involvement
- ☐ DCFS involvement
- ☐ Homeless
- ☐ Current thoughts of self-harm/suicide
- ☐ Past thoughts of self-harm/suicide
- ☐ Prior suicide attempts
- ☐ Current thoughts of harming others
- ☐ Past thoughts of harming others
- ☐ Current/history of injuring animals
- ☐ Recent trauma exposure
- ☐ Victim of violence/abuse
- ☐ School Issues or IEP in place
- ☐ Current substance use/abuse
- ☐ Past substance use/abuse
- ☐ Bully/Cyberbully victim or aggressor
- ☐ Past/Recent runaway

Impairments

Check any area below in which the client appears to have significant impairment(s) or the probability of deterioration

- ☐ Living Arrangement
- ☐ Social Support
- ☐ Daily Living/Education
- ☐ Physical Health

Other

Does the client require interpretation? ☐ YES ☐ NO

Does the caregiver require interpretation? ☐ YES ☐ NO

Does the caregiver agree to work with an interpreter? ☐ YES ☐ NO

Intake contacted CPS for SCAR? ☐ YES ☐ NO Date: _____

Date minute or court order requested _____

Custody arrangement _____

If joint, what is other parent's name/#? _____

Intake Summary

☐ Emergency/Urgent enrollment ☐ General enrollment ☐ Refer to community agency

Program recommendation: ☐ BHS ☐ RRR

Treatment recommendation: ☐ CPP ☐ FOCUS ☐ GMH ☐ ICBT ☐ MAP ☐ PCIT ☐ TFCBT ☐ Other _____

Taken by _____ Date assigned _____ Intake Clinician _____

Date Received _____ Clinician _____

☐ Enrollment
☐ Assessment