Child Behavioral Wellness Referral Form

SANTA BARBARA COUNTY DEPARTMENT OF Behavioral Wellness
A System of Care and Recovery

Referring Party Information:

Date of Referral: ___ / ___ Name of Person Making Referral: _____

Referring Program: _____

Program Referred To: _____ Phone Number: (_____) _____

Signature of Person Completing Referral: _____ Print Name: _____

Identifying Information of Person Being Referred: Name: _____

DOB: _____ / _____ / _____ Clinician's Gateway Consumer ID: _____

Sex/Gender: _____ Language Preference: _____ Parent / Guardian Name: _____

Address: _____ Phone: (_____) _____

Clinical Information: *Reason for Referral*

Functional Impairments (Academic/Employment/Legal/ADL/Interpersonal/Placement): _____

_____

_____

# of Psych Hospitalizations in Last 2 Yrs: _____ Reasons: _____

Problematic Use of Substances? Yes / No Drug of Choice: _____ Last Use: _____

Risk of Harm / Dangerous Propensities (e.g., Suicidal/Homicidal Attempts): Yes / NO

Diagnoses / Authorizations / Pertinent Dates:

Primary Diagnosis: _____ Secondary Diagnosis: _____

Date Health History Questionnaire Completed: _____ / _____ Date of Most Recent Assessment: _____ / _____

Date of Most Recent Treatment Plan: ____ / ____ Date of Most Recent Treatment Authorization: _____ / _____

CANS Rating Score & Date: _____ Date of Most Recent KATIE A Assessment: _____ / _____

Medical Issues / Medications: _____

_____

Primary Care Physician/Pediatrician: _____ Phone Number: (_____) _____

Date of Last Physical Examination: _____ / _____

Legal Information:

Is the Minor Conserved? _____ Name of Conservator: _____ Phone: (____) _____

Is the Minor WIC 300 / 601 / 602? Name of Social Worker: _____

Is there a history of incarceration and/or Legal/Forensic Issues? YES / NO

Minor is on: Probation / Parole Probation Officer: _____ Phone: (_____) _____

Other Pertinent Legal Information or Restrictions: _____

Financial / Insurance Information:

Current Source of Income: SSI / SSDI / Work / Other: _____

Does this person have a Payee? Yes / No Name of Payee: _____

Current Insurance Status: Medi-Cal / Medi-Care / Indigent / Other: _____

To be Completed by Recipient of Referral:

Date Received: _____ / _____ Staff Contacted Person on: ____ / ____ Was Person Admitted? Yes / No

If No, Why? _____Admission Date: _____ / _____ Primary Case Manager: _____

Referring Program Informed of Disposition: Yes / No / Date: _____ / _____ Returned to Be-Well Supervisor: Yes / No

For Additional Information about the disposition of this referral, please contact Quality Care Management: (805) 681-4908.