Form update on- July 2014

Star View Community Services- Referral Form
Phone: 888-535-3288 Fax: 310-868-5396

MIS #_________________________ SPA ___________

OFFICE USE ONLY
Date Received _____/_____/_____Date Delivered _____/_____/_____

Referring Party/Caller: ____________________________ **Relation/Agency Name:** ____

Address: ____ **Phone:** ______________________________ **Fax:** __________________

Client Information:

Name: ___________________________________ **Age:** _____________ **DOB:** __________ **SSN:** _____________________**Gender: F ☐ M ☐**

Ethnicity: ________________________ **Child's Primary Language:** ___________________**Caregiver's Primary Language:** ____________________

Primary Caregiver(s) Name____

Address: ____**City:** _____________________________**Zip:**____________________

Home Phone: __________________________ **Cell Phone:** __________________________________ **Alternate Phone:** ______________________

Childs's Placement: *Parent☐ Relative☐ Non-Relative Extended Family☐ Legal Guardian☐ Foster Parent☐ Group Home☐ FFA Home☐ FFA/Group Home FFA Social Worker's Name: _______________________ Phone: ________________________*

Biological Parent Name: ______________________________________**Phone:** _____________________ **Primary Language:** __________________

Medi-Cal: ***Yes☐ No☐*** **Number:** ____ **Issue Date:** ____________________________

Other Health Coverage: Yes ☐ No ☐ Carrier Name: ____________________________________ **Group/Policy/ID#:**___________________________

Current Services:

MAT case: Yes ☐ No ☐ **MAT Assessor:** ____________________________ **Phone:** __________________ **Clinic:** ________________

DCFS: Yes ☐ No ☐ **CSW Name:** ___________________________________ **Phone:** __________________ **Fax:** _________________

Probation: Yes ☐ No ☐ **DPO Name:** ______________________________ **Phone:** __________________ **Court Date:**_____________

DMH Therapist: Yes ☐ No ☐ ____________________________________ **Phone:** __________________ **Clinic:** ________________

Psychiatrist: Yes ☐ No ☐ ______________________________________ **Phone:** _________________ **Medications:** ____________

School: ____ **Grade:** _____________ **Special Education/IEP**: Yes ☐ No ☐

Previous Services:

Previous services with Star View? Yes ☐ No ☐ or **Previous services with another mental health agency?** Yes ☐ No ☐

Agency Name: ________________________________ Therapist: ___________________________________ Phone: ______________________

History of Psychiatric Hospitalizations: Yes ☐ No ☐ Date of last hospitalization: ____

Regional Center services? Yes ☐ No ☐ RC Worker: ____ Phone: _____________________________

BEHAVIORAL PROBLEMS AND MENTAL HEALTH SYMPTOMS *(Check all that apply & provide a description):*

Anxious/Nervous ☐ Sad/Depressed ☐ Delinquent/Defiant ☐ Aggressive/Violence ☐ Homicidal ☐ Irritable/Mood Swings ☐ Hyperactive /Impulsive/Inattentive ☐ Suicidal/Self-Harming ☐ Substance Abuse ☐ Sexualized Behavior ☐ Eating Disorder ☐ Odd Thoughts ☐ Seeing/Hearing Things ☐

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AREAS IN WHICH CLIENT IS HAVING DIFFICULTY *(Check all that apply & provide description):*

Health/Medical Issues ☐ School failure ☐ Family relationships ☐ Peer relationship ☐ Living Skills ☐ Experienced a significant trauma ☐ Safety ☐ Development Delay or Autism ☐ Contact with law enforcement ☐ Homeless ☐

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Is client's p*lacement in jeopardy due to behaviors? Yes ☐ No ☐*

ASSESSMENT USE ONLY:

Referral Assigned to: __________________***Date:*** ____________ ***Program:*** _________________***Team:***______________