

Interface Mental Health Services Referral Form



Referral/Screening Source

Referral Date: _____

Referring person: _____

Relation to client: _____

Agency Name/Address: _____

Phone : _____

Client Information

Last name: _____ First name: _____ MI: _____

Primary Language: English Spanish Other: _____ Date of Birth: _____

Parent or Caregiver info: Name: _____ Relationship to client: _____

Home Phone : _____ Cell Phone: _____ Work Phone: _____

Address: _____

City: _____ Zip: _____

Current Services: Probation Drug and Alcohol Special Education Public Health Wrap TBS
Regional Center CFS: Worker's Name/Number: _____

Insurance Status: Medi-Cal # _____ Issue Date: _____
 None Private or other insurance Unkown

Presenting Problem/Background: _____

History

1. Family History of: Mental disorder Incarceration Substance abuse Domestic violence
2. Experienced/witnessed abuse, violence, trauma, or neglect? Yes No Unknown
Sex Abuse (witness victim) Neglect (witness victim) Physical Abuse (witness victim) Trauma (witness victim)
3. Significant exposure to teratogens (alcohol, drugs, lead, etc.)? Yes No Unknown
4. History of mental health treatment/intervention? Yes No Unknown
Psychiatric hospitalization Therapy School counseling Residential
Psychiatric meds: _____

Urgent & Emergency Questions

1. Danger to self or others in the last 30 days? Yes No Unknown

If Yes, please describe: _____

2. Bizarre/unusual behavior in the last 30 days? Yes No Unknown

If Yes, please describe: _____

Routine Questions

1. Social adjustment problems? Yes No Unknown

Damages own/others property Runs away Lack of guilt Steals Fights Mute

2. Difficulty managing emotions? Yes No Unknown

Severe temper tantrums Nightmares Overactive Cries inconsolably

Feels hopeless Sad/withdrawn Feels worthless Excess worry

3. Problems making and maintaining healthy relationships? Yes No Unknown

Poor peer relationships Poor bond with caregiver Gang involved Provokes & victimizes

4. Personal care problems? Yes No Unknown

Frequently wets or soils self Eats/drinks things that aren't food Poor hygiene

5. Significant functional or daily living problems? Yes No Unknown

Significant language delays Can't manage age appropriate skills

Difficulty sleeping Difficulty understanding others

6. Child of parental abuse or alcohol and/or drugs? Yes No Unknown

Meth/Stimulants Cannabis Alcohol Other: _____

Additional Questions

1. *What grade and school is child attending?*

2. *Does child receive Wraparound services?*

3. *Is the child in any special education, resource classes or receiving special assistance through the school?*

4. *Does the child have an IEP?* Yes No Unknown

Or is one scheduled? Yes No Unknown - If so when? _____

English Statement

I understand that my child is being referred to Interface Children & Family Services for mental health services. I understand that my participation with my child is essential. I hereby give my consent for the exchange and release of information for this purpose.

Spanish Statement

Entiendo que mi niño está siendo referido al Interface Children & Family Services para servicios de Salud Mental. Entiendo que mi participación con mi niño es esencial. Doy por este medio mi consentimiento para el intercambio y el lanzamiento de información para este propósito.

Authorized Signature (Parent or Guardian)

Date

**Complete and fax to Interface Mental Health Services Intake Dept. 805-278-4391
Questions: Contact Intake Dept. 805-485-6114 ext. 662**