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: ____________________

Do we have permission to leave a msg? Yes ☐ **No** ☐

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:____

____

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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☐Feels hopeless ☐Sad/withdrawn ☐Feels worthless ☐Excess worry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