** Mental Health & Trauma Treatment Services**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Referral/Screening Source** | | | Referral Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Referring person: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  |
| Agency Name/Address: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

**Client Information**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Last name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | First name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | MI:\_\_\_\_ | |  | |
| Client Primary Language: English Spanish Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_  **Parent Information**  Parent, Legal Guardian or Caregiver: Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to client:\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Language: English Spanish Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Home Phone :\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Insurance Status:** Medi-Cal #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Issue Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Other Insurance/Name/#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Active Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Unkown  None | | | | | | |

**School Information**

School District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School: Elementary \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Jr. High \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason Services are Being Requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**History**

*Family History of:* Mental health concerns Incarceration Substance abuse Domestic violence

*Experienced/witnessed abuse, violence, trauma, or neglect?* Yes No Unknown

|  |
| --- |
| Sexual Abuse(witness victim) Neglect(witness victim)Physical Abuse(witness victim) Trauma(witness victim) |

*Client history of mental health treatment/intervention?* Yes No Unknown

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Psychiatric hospitalization | Therapy | School counseling | Residential |

**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*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*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. You may contact me on my home phone, cell phone, text, email.

 I attest to the right to sign consent for this referral. I give verbal consent for contact and referral.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Signature (Parent or Legal Guardian) Date

**Complete form and click here to submit to** [**intake@icfs.org**](mailto:intake@icfs.org) **Questions: Contact Intake Dept. 805-485-6114 ext. 662**