# REFERRAL FOR MENTAL HEALTH/SUBSTANCE ABUSE SERVICES

Walk in ☐ Phone Call ☐ Agency Referral ☐ Date of Referral_____

**CLIENT INFO**

Last_____First_____MI_____DOB_____ Age_____

Sex: Male☐ Female ☐SSN#: _____ Language of Choice_____

Address:_____ Telephone No._____

Parent/Guardian_____

**REFERRAL SOURCE**

Self ☐ Agency ☐ Name of Referring Agency_____

SARB ☐ Address:_____

Name of referring person_____Phone_____

**Program referring to**: **Mental Health** ☐ **Substance Abuse** ☐

**REASON AND OBJECTIVE OF REFERRAL**

- Is this a Crisis or emergency? Yes☐ No ☐ ●Is Individual a danger to self or others? Yes☐ No☐
- Has Individual received MH services in the past? Yes ☐ No☐
- If yes, when and where?_____
- Does Individual take medication? Yes☐ No☐ If Yes, name of medication: _____
- Has the individual used opiates in the last 30 days? Yes ☐ No ☐
- Other information_____

_____

_____

**FINANCIAL RESPONSIBILITY**

Does individual have San Benito County Medi-cal? Yes ☐ No ☐

If yes, medi-cal card number_____(copy of card when available)

Private Insurance? Yes☐ No☐ If yes, name of insurance_____

Private Pay Responsible Party_____

CPS authorized payment Yes☐ No☐ Number of authorized visits_____

Name of authorized CPS representative_____

**OTHER RELEVANT INFORMATION**

Other agencies involved, available test results, legal status etc.

_____

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_____

**RELEASE OF INFORMATION**

I, _____hereby agree to the release of the above information to the San Benito County Behavioral Health Department for the purpose of planning, assessment, and treatment and I further give permission to San Benito county Behavioral Health Services to discuss this referral with the referral source.

Client:_____ Witness:_____

**MGR REVIEWER** ( for BH staff only)

Schedule Intake☐ Respond to agency ☐ Assigned intake staff_____ Date of appt:_____

**SAN BENITO COUNTY BEHAVIORAL HEALTH SERVICES REFERRAL**

**CLIENT NAME**_____

**CHART NUMBER**_____

**DATE:**_____