This document may contain PHI. Please ensure HIPAA compliance by sending via secure email or fax

If this is a life-threatening emergency, please do not complete this form and go to your nearest emergency department or call 911. If you have an immediate mental health or substance use need, please do not complete this form and call 916-875-1055

SACRAMENTO COUNTY

Department of Health Services
Division of Behavioral Health Services

Print

Behavioral Health Services – Screening and Coordination Service Request

Submit the completed form to BHS-SACFax@saccounty.gov

Instructions: List one person per form. **Incomplete forms will be returned for additional information.**

Request type: ☐ Mental Health ☐ Substance Use ☐ Adult ☐ Child/Youth

Phone: (916) 875-1055 **Toll Free: 1-888-881-4881** **Fax: (916)-875-1190**

Submitting Agency: _____ Phone: _____

Submitting Party Name: _____ Date: _____
(Last, First)

Phone: _____ Fax: _____ Email: _____

Submitting Entity: ☐ **Per 42 CFR, this member agrees with this referral and submits to coordination of care to occur on their behalf.**

☐ Self-Referral ☐ CalWORKs/DHA ☐ CPS Social Worker ☐ Hospital ☐ Parole ☐ Probation
☐ Other: _____

Associated Population:
☐ AAP-Out of County Medi-Cal ☐ AAP – Sacramento County Medi-Cal ☐ Regional Center ☐ Homeless
☐ Older Adult ☐ Correctional Health ☐ Other County Medi-Cal (Please list): _____

Person Being Referred:

Last Name: _____ First Name: _____

Birth Name (if different): _____ Phone: _____ Gender Identity: _____

SSN: _____ DOB: _____ Race: _____ Ethnicity: _____ Primary Language: _____

Birth Mother's First Name: _____

Street Address: _____ City: _____ State: ____ Zip Code: _____

Parent/Caregiver Information:

Last Name: _____ First Name: _____
Street Address: _____ City: _____ State: ____ Zip Code: _____
Phone: _____ Alt. Phone: _____ Relationship: _____ Primary Language: _____

Risk Factors: ☐Current Homicidal Ideation ☐ Recent or Imminent Discharge from a Psychiatric Hospital
☐ Domestic Abuse ☐ Homelessness ☐ Sexual Abuse ☐ Current Suicidal Ideation

Mental Health Presenting Problems (Check all that apply) **(Please complete this portion only if you are seeking mental health services)**

☐Anti-Social behavior	☐Delusions	☐Frequent nightmares	☐Paranoia
☐Anxiety	☐Euphoric	☐Depressive Mood	☐Grandiosity
☐Poor Concentration	☐Irritability	☐Appetite problems	☐Developmental Issues
☐Hallucinations	☐Self-injurious	☐Chronic pain	☐Disorganized thoughts
☐Hyperactivity	☐Sleep Difficulties	☐Cries excessively	☐Does not bond
☐Inappropriate Guilt	☐Cruelty to Animals	☐Enuresis/Encopresis	☐Victimizes others
☐Defiant/Oppositional	☐Fire Setting	☐Inappropriate sexual behv.	☐Obsessive-compulsive

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Psychiatric history/Treatment history:

Services requested:

Additional Information: (i.e. cultural issues, physical health problems, APS/CPS/Probation involvement, assistance needed with ADL's, transportation issues, special education, names of schools. (Attach additional page if needed).

Substance Use and Drug History and Recent Events (Please complete remainder of form only if you are seeking substance use disorder services)

Substance Use (Check all that apply)

☐ Admitted drug use ☐ DUI ☐ Mother positive at birth ☐ Prior CPS case with drugs

☐ Drug arrests ☐ Failure to drug test ☐ Paraphernalia in home ☐ Prior pos-tox births

☐ Drugs found in home ☐ Infant positive at birth ☐ Prenatal exposure ☐ Prior SUD Tx history

Drug (s) of choice related to qualifying events (Check all that apply):

☐ Alcohol ☐ Ecstasy/Club drugs ☐ Marijuana ☐ Opiates ☐ Hallucinogens
☐ Benzodiazepine ☐ Methamphetamine ☐ Cocaine/Crack ☐ Heroin ☐ Misuse of prescriptions
☐ Other: _____

Criminal justice history (Check all that apply)

☐ 290 Registrant ☐ Hold from another county ☐ Intoxicated in public

☐ 452 Arson registrant ☐ Drug possession ☐ Intent to sell ☐ Pending drug charges

Summary/Reason for referral: Specific details and dates of the above checked boxes, includes AOD/SUD related history as well as treatment episodes, arrests, CPS, family & domestic violence, and current drug test results including failure to test(s).

Date of last use: _____ Date of failure (s) to test: _____

Current drug use: ☐ Yes ☐ No Current AOD/SUD services: ☐ Yes ☐ No

Additional Information: (i.e., cultural issues, physical health problems, APS/CPS/Probation involvement, Description of qualifying events and all previous AOD/SUD history: (Attach additional page if needed)