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| Sacramento County Seal Image**BEHAVIORAL HEALTH ASSESSMENT AND LINKAGE REFERRAL*****Please complete the following section for the inmate patient/client being referred.*** |
| **REQUEST:** **[ ]  Urgent: 48 hours of release** **[ ]  Routine: 10 business days of release** **Projected Release Date (must be within 90-day):** |
| **Telehealth (required for out-of-county referrals) Provided by Facility** **[ ]  Yes** **[ ]  No**  |
| **Interpreter Needed:** **[ ]  Yes** **[ ]  No**  | **Primary Language:**  |
| **Client/IP Name:**        |
| **DOB:**       | **SSN:**       | **Medi-Cal Client ID #:** |
| **CDCR:**       | **X-Ref:**       | **JI Aid Code(s):** **[ ]  12** **[ ]  13** **[ ]  14** **[ ]  15** **[ ]  16** |
| **Referring Facility:**       | **Facility County:**        |
| **Facility Contact Name:**  | **Facility Contact Phone:** **Facility Contact Email:**  |
| **Relevant Mental Health information:**  **Source(s):**       |
| **Substance Use:** **[ ]  Yes** **[ ]  No** **[ ] UNKNOWN** | **Preferred drug(s):**  |
| **Substance Use History/Concerns:**  |
| **Charges/Description & Other notes:**      **History of/Charge of/Conviction of 290 or Arson?** **[ ]  Yes** **[ ]  No** | **Victim related crime:** **[ ]  Yes** **[ ]  No****Special orders** *(check all that apply)***[ ]  Cannot reside with victim** **[ ]  No contact order** **[ ]  Restraining order** **[ ]  N/A** **[ ]  Peaceful contact order**  |
| **Client Contact Number on release:**  | **Homeless:** **[ ]  Yes** **[ ]  No**  |
| **Address upon release:**  | **Income source/funding:**  |
| **FACILITY CONTACT REVIEW** ***Please review the information provided above is accurate and correct.*** ***Submit completed referral form and ROI to:***  ***dhs-bhs-jailreferral@saccounty.gov.*** |
| **Reviewed By** *(PRINT)***:**  | **Date:**  |
| *(SIGNATURE)***:**  | **Phone:**  |
| **DEPARTMENT OF HEALTH SERVICES, BEHAVIORAL HEALTH SERVICES** |
| **ROI Date:**  | **Date of assignment:**       | **Completion date:**       |
| **Mental Health Diagnosis:**       | **Primary** **[ ]  Yes** **[ ]  No**  |
| **Substance Use Diagnosis:**       | **Primary** **[ ]  Yes** **[ ]  No**  |
| **Level of Care Recommendation:** **[ ]  MCP** **[ ]  CORE/OP** **[ ]  FSP** **[ ]  Not Eligible for MHP** **[ ]  Other** *(see notes)*Other |
| **SUPT Treatment Recommended:** **[ ]  No** **[ ]  Yes** *(specify)***:** |
| **Recommendation Notes:**  |
| **Assigned SMHC** *(PRINT/SIGN)***:**  |  **Date:**  |