|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 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:** | | | |