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| Sacramento County Seal Image**BEHAVIORAL HEALTH SERVICES** **REFERRING AGENCY SECTION** |
| **Client Name:**        | **X-Ref:**        **Case(s) #:**       |
| **DOB:**       | **SSN:**       | **Insurance:**       | **In Custody: [ ]  Yes - Facility:**       **[ ]  No**  |
| **Referring Agency:** **[ ]**  **PD [ ]  CCD** **[ ]  DA [ ]  Probation** | **Court Dept.:**       |
| **Court: [ ]  MHTC [ ]  Felony MHD [ ]  Misdo MHD [ ]  Prop 36** **[ ]  CORE DA** **[ ]  Recovery Court** **[ ]  Re-Entry Court** |
| **[ ]  IST**  | **[ ]  Participated in Competency Hearing Program. Date:**       |
| **Current Mental Health Provider:**       | **Provider and number:**       |
| **Relevant Mental Health information:**       **Source:**       |
| **Substance Use: [ ]  Yes [ ]  No [ ]  UNK**  | **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:**       |
| **Interpreter Needed: [ ]  Yes [ ]  No**  | **Language:**       |
| **REFERRING AGENCY CONTACT REVIEW*****Please review the information provided above is accurate and correct.******Submit completed referral form and ROI to: dhs-bhs-mh-courts@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 [ ]  FSP [ ]  Not Eligible for MHP [ ]  Other** *(see notes)*Other |
| **SUPT Treatment Recommended: [ ]  No [ ]  Yes** *(specify):*      |
| **Recommendation Notes:**        |
| **Assigned SMHC** *(PRINT/SIGN)***:**       | **Date:**       |