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| Sacramento County Seal Image**BEHAVIORAL HEALTH SERVICES**  **REFERRING AGENCY SECTION** | | | | | | | | | |
| **Assessment Request (Check all that apply):**  **Mental Health**  **Substance Use Disorder** | | | | | | | | | **Priority** |
| **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** | | | | | | | | | |
| **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**  **Arson**   **N/A** | | | | | **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:** | | |