SACRAMENTO COUNTY

TFC REFERRAL FORM

Referral Date: _____

Email form and attachments to TFCReferrals@saccounty.net or fax to 916-854-8854 ATTN: TFC Contract Monitor.
Incomplete referrals may delay the processing.

CLIENT INFORMATION

Name: _________ DOB: ________ Sex at Birth: Choose an item. Language: ____________ SSN: __________

Address: ______________________________ Phone: ____________________

Caregiver Name: _______________________ Language: ________________________

Address: _______________________________ Phone: _____________________________

Type of Current Placement: Choose an item.

REFERRING PARTY

Referring SW/Probation/Mental Health Provider Clinician: __________________________________
Desk Phone: ___________ Cell Phone: ______________ Email: _________________________

Supervisor: __________________________________
Desk Phone: ___________ Cell Phone: ______________ Email: _________________________

Case Type: Choose an item.

MENTAL HEALTH AND/OR SUSBTANCE USE PREVENTION AND TREATMENT SERVICES (SUPT)

Previous mental health or SUD services? (check all that apply)

☐ Outpatient ☐ FIT ☐ TBS ☐ Full Service Partnership ☐ Wraparound ☐ TFC
☐ Psychiatric Hospitalization ☐ SUD ☐ ERMHS ☐ None ☐ Other: ___________

Current and active mental health or SUD services? (check all that apply)

☐ Outpatient ☐ FIT ☐ TBS ☐ Full Service Partnership ☐ Wraparound ☐ TFC
☐ Psychiatric Hospitalization ☐ SUD ☐ ERMHS ☐ None ☐ Other: ___________

SCHOOL INFORMATION

School: __________________________ Grade: ____ Ed Rights Holder: ____________________

MEDICAL INFORMATION

Hospitalizations: Choose an item. Hospitalization Details: _____________________________________

Psychotropic Medications: Choose an item. If yes, attach JV220 or list below: ____________________

CLINICAL RATIONALE FOR TFC SERVICES (REQUIRED):

Client meets medical necessity due to …____
____
____
____

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STRENGTHS (Required):

☐ Access to transportation
☐ Cares about animals
☐ Cares about others
☐ Communicative
☐ Cooperative
☐ Creative
☐ Developmentally on track
☐ Family involved
☐ Good hygiene
☐ Good connection to a community
☐ Has hobbies
☐ Good sense of humor
☐ Has medical care
☐ Permanency Plan
☐ Physically healthy
☐ Independent
☐ Is a leader
☐ Likes school
☐ History of placement stability
☐ Shares
☐ Stable housing
☐ Has friends
☐ Connected with culture/religion/faith
☐ Other

CHALLENGES/NEEDS THAT INTERFERE WITH YOUTH'S QUALITY OF LIFE OR JEOPARDIZES PLACEMENT (Required):

☐ Alcohol or drug use issues
☐ Preoccupied with anxiety
☐ Assaultive
☐ AWOLS
☐ Conflict with authority
☐ Cruelty to animals
☐ Depressed/withdrawn
☐ Defies authority
☐ Death of significant person
☐ Does not want reunification
☐ Domestic violence
☐ Multiple placements
☐ Fire setting
☐ Poor nutrition habits
☐ Follower
☐ Disconnected from community
☐ Gang affiliation
☐ Hallucinations
☐ Physical disability
☐ Insecure housing
☐ Hyperactive
☐ Incarceration
☐ Isolated
☐ Nightmares
☐ Limited family contact
☐ Has ongoing medical needs
☐ Mood swings
☐ Neglect
☐ Need for permanency
☐ Property damage
☐ History of physical abuse
☐ Disconnected from faith/religion/culture
☐ Poor attachment
☐ Poor school attendance
☐ Parental mental health issues
☐ Pregnancy
☐ Refuses counseling
☐ Self-injury
☐ Shows no remorse
☐ Sleep issues
☐ Suicidal talk/ideation
☐ Temper/anger control
☐ Victimizes
☐ Violent crime witness
☐ 3+ placements in last 24 months
☐ History of sexual abuse
☐ At risk of exploitation/CSEC
☐ Other

CHILD AND FAMILY TEAM (CFT) (REQUIRED)

Has a CFT been convened and the team agreed with the TFC referral? ☐ No ☐ Yes, Date: ________

If No, when will CFT be convened to discuss service options? Date: ________

Indicate which of the following documents you have **attached**: **(* indicates required document)**

☐ **TFC Screening Tool*** ☐ **CFT Minutes*** ☐ JCE 366 ☐ Other: ________

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