COMMUNITY SUPPORT TEAM (CST) REFERRAL FORM

Hours of Operation: Monday – Friday, 8:00 a.m. – 5:00 p.m.
Telephone: (916) 874-6015 **REFERRAL EMAIL:** CSTServiceRequest@saccounty.net

THIS REFERRAL FORM MAY BE USED ONLY FOR NON-EMERGENCY REQUESTS. PLEASE CALL 9-1-1 FOR EMERGENCY SERVICE REQUESTS.

REFERRING PARTY INFORMATION		
Name of Contact:	**Agency & Program Name:**	
Today's Date:	**Time:**	**Telephone Number:**
Fax Number:	**E-mail:**	

SUPPORT REQUESTED FOR		
Name:	**Date of Birth:**	**Age:**
Home Phone:	**Cell Phone:**	**E-mail:**
Address:	**City:**	**Zip Code:**
☐ Male ☐ Female ☐ Other ☐ unk **Race:** Select Race	**Ethnicity** (Hispanic or Latino): ☐ Yes ☐ No ☐ Unknown	
Primary Language:	**Interpreter service recommendation:** ☐ Yes ☐ No	
Can we contact this person directly? ☐ Yes ☐ No If no, Contact Name and Phone Number:		
Concerns and/or Services Requested (reason for referral, symptoms, behaviors, risks, needs for support):		
***Please identify current stressors or areas of focus for support that would improve sense of health and wellness*:** ☐ Mental Health navigation/resources ☐ housing/ living situation ☐ legal ☐ medical ☐ social / recreational ☐ education/ employment ☐ financial ☐ concrete needs (food/clothing) ☐ safety ☐ self-care		
History of Mental Health treatment:	**Use of traditional or alternative healing practices:**	
SSN:	**Insurance Coverage : Select Insurance Coverage** Select	

CST OFFICE USE ONLY	
☐ URGENT REFERRAL ☐ STANDARD REFERRAL	
REFERRAL RECEIVED BY: Telephone ☐ Fax ☐ E-mail ☐ In-Person ☐	**RECEIVED BY:** **DATE RECEIVED:** **ASSIGNED TO:**

IF THIS IS AN EMERGENCY, PLEASE CALL 9-1-1 FOR EMERGENCY RESPONSE AND SUPPORT SERVICES.