

San Diego County HHS Adult/Older Adult Mental Health Services Strengths-Based Case Management and ACT Referral Form

Additional information may be requested to assess program eligibility. If you are unclear where to refer the person, please fax the above information to (619) 542-4969 or call (619) 692-8715.

REFERRAL BEING MADE TO STRENGTHS-BASED CASE MANAGEMENT (SBCM) PROGRAM/S

- County Case Management: (619) 692-8715; Fax: (619) 542-4969
 East County Case Management: (619) 692-8715; Fax: (619) 542-4969
 CRF Case Management South: For the Northern part of South Region contact (619) 427-4661, Fax: (619) 426-7849; For the Southern Region part of South Region contact (619) 428-1000, Fax (619) 428-1091
 MHS Inc. Case Management North: (760) 432-9884; Fax: (760) 432-9953
 North County TAY CM: (760) 758-1092; Fax: (760) 758-8481
 Telecare AgeWise Older Adult CM: (619) 481-5200; Fax: (619) 481-5217

REFERRAL BEING MADE TO ASSERTIVE COMMUNITY TREATMENT (ACT) TEAM/S

- Telecare Pathway: (619) 683-3100; Fax: (619) 682-4037
 Telecare Gateway: (619) 683-3100; Fax: (619) 682-4037
 CRF IMPACT: (619) 398-0355; Fax: (619) 398-0350
 CRF Downtown IMPACT: (619) 398-2156; Fax: (619) 398-2168
 MHS Inc. Center Star ACT: (619) 521-1743; Fax: (619) 521-1896
 MHS Inc. North Star ACT: (760) 432-9884; Fax: (760) 432-9953
 Providence Catalyst ACT: (858) 300-0460; Fax: (858) 300-0461
 CRF Senior IMPACT: (619) 977-3716; Fax: (619) 481-3075

REFERRING PARTY INFORMATION

Date of Referral: ____/____/____ Name of Person Making Referral: _____
 Referring Agency: _____ Address: _____
 Phone: _____ Fax: _____

IDENTIFYING INFORMATION OF PERSON BEING REFERRED

Name: _____ SS# (Last 4 ONLY): _____ DOB: ____/____/____ MIS#: _____
 Aliases: _____ Gender: _____ Language of Preference: _____
 Address: _____ Phone: _____
 Has he/she ever been Homeless? YES NO Period of Homelessness: _____
 Emergency Contact: _____ Relation: _____ Phone: _____

CLINICAL INFORMATION

Is Person Interested in Case Management? YES NO Provide Specific Reason(s) for Referral: _____

Current Problems, Barriers, Challenges, OR Problems When Person is Not Stable: _____

Mental Health Stage of Recovery: Pre-Contemplation Contemplation Preparation Action Maintenance Relapse

History of Mental Health Treatment: _____

Number of Psych Hospitalizations in the Last 2 Years: _____ Reasons: _____

Does Person Have Problematic Use of Substances? YES NO Date of Last Use: ____/____/____

Substance(s) of Choice: _____

Substance Use Stage of Recovery: Pre-Contemplation Contemplation Preparation Action Maintenance Relapse

History of Drug/Alcohol or Co-Occurring Treatment: _____

Risk for Harm or Dangerous Propensities (e.g., Suicide Attempts, SI, HI, Command AH, Hx of Violence, Threats, Risky Behavior): _____

Current Impairments in Daily Functioning: _____

Goals, Strengths, and Interests: _____

DIAGNOSES

Axis I (Primary): _____

Axis I (Secondary): _____

Axis II: _____

Axis III: _____

Axis IV: Primary Support Social Environment Educational Occupational Housing
 Economic Access to care Legal system Other _____

Axis V: Current: _____ Year High: _____

CURRENT MEDICAL ISSUES

Primary Care Physician: _____ Phone: _____

CURRENT MEDICATIONS

Current Treating Psychiatrist: _____ Phone: _____

LEGAL INFORMATION

Is Person Conserved? YES NO Name of Conservator: _____ Phone: _____

Has Person been Incarcerated or Had Legal Issues? YES NO If yes, please explain: _____

Person is on... Parole Probation N/A Parole/Probation Officer: _____ Phone: _____

Other Pertinent Legal Information or Restrictions: _____

FINANCIAL / INSURANCE INFORMATION

Current Source of Income: SSI SSDI SDI WORK NONE Other: _____

Payee: _____ Phone: _____

Current Insurance Status: Medi-Cal Medicare VA Indigent

Medi-Cal #: _____ Medicare #: _____

Private/Other Insurance Information: _____ Policy #: _____ Phone: _____

Signature of Person Completing Referral: _____ Date: ____/____/____

TO BE COMPLETED BY RECIPIENT OF REFERRAL

Received: ____/____/____ Logged By (Initials): _____ Staff Contacted Person On: ____/____/____ Contacted by (Initials): _____

Was person admitted? YES NO Disposition: _____

Staff informed _____ at referring agency of disposition on ____/____/____. Informed by (Initials): _____