County of San Diego HHSA BHS Program and Services
ASSERTIVE COMMUNITY TREATMENT (ACT) and STRENGTHS-BASED CASE MANAGEMENT (SBCM)
REFERRAL FORM

Please note: *Please ensure that the person being referred is aware of the referral and willing to participate in services (unless under LPS Conservatorship). The referral process typically takes up to 10 days. If you have an immediate mental health crisis, please contact the Access and Crisis Line at 888-724-7240 or dial 911 for medical emergencies.*

Select Level of Care: ◯ STRENGTHS-BASED CASE MANAGEMENT (SBCM) ◯ ASSERTIVE COMMUNITY TREATMENT (ACT)

1. REFERRING PARTY INFORMATION

Date of Referral:	**Name of Person Making Referral:**	
Email of Referring Party*:	**Referring Agency:**	
Phone:	**Fax:**	**Address:**

*If choosing to communicate via e-mail, please ensure compliance to Article 14 and confidentiality requirements. E-mail may be used between providers and referring parties as long as no client information is included unless encryption is used. This referral form should never be sent via email unless encrypted.

2. IDENTIFYING INFORMATION OF PERSON BEING REFERRED

Name:	**DOB:**	**Age:**	**CCBH#:**
Aliases:	**SS# (Last 4 Only):**	**Gender:** ☐ M ☐ F ☐ O	
Language of Preference:	**Race:** --- Please Select ---	**Ethnicity:** --- Please Select ---	
Address:	**Zip Code:**	**Phone:**	
Currently Homeless or at risk of becoming Homeless? ☐ Yes ☐ No		**Period of Homelessness:**	
Alternate Contact or Other Supports:	**Relationship:**	**Phone:**	

3. CLINICAL INFORMATION

Provide Specific Reason(s) for Referral:

History of Mental Health Treatment:

Number of Psych Hospitalizations in the past year:	**Reasons:**

CURRENT RISK ASSESSMENT

Suicidal: ☐ No ☐ Ideation ☐ Plan ☐ Intent ☐ History of harming self

Homicidal: ☐ No ☐ Ideation ☐ Plan ☐ Intent ☐ History of harming others

Dangerous Behaviors: ☐ Yes ☐ No	**If yes, please explain:**

Current Impairments in Daily Functioning:

Does person have Problematic Use of Substances? ☐ No ☐ History ☐ Current ☐ Unknown	Date of Last Use:
Substance(s) of Choice:	
Substance Use Stage of Recovery: ☐ Pre-Contemplation ☐ Contemplation ☐ Preparation ☐ Action ☐ Relapse	
History of Drug/Alcohol or Co-Occurring Treatment:	

4. GOALS, STRENGTHS, INTERESTS

5. CULTURAL FACTORS RELATED TO BEHAVIORAL HEALTH

6. DIAGNOSES (IF UNKNOWN, PLEASE DESCRIBE BEHAVIORAL HEALTH SYMPTOMS)

Primary:
Secondary:
Other(s):
Psychosocial and contextual factors (use V&Z codes most relevant to the mental disorder):

7. CURRENT MEDICATIONS

Current Treating Psychiatrist:		Phone:	
Name of Medication:	**Medication Dosage:**	**Name of Medication:**	**Medication Dosage:**

☐ **No Medications**

8. CURRENT MEDICAL ISSUES

List any current medical issues:	
Primary Care Physician:	**Phone:**

9. LEGAL INFORMATION

Is Person Conserved? ☐ Yes ☐ No ☐ Unknown	
Name of Conservator:	**Phone:**
Has Person been Incarcerated or Had Legal Issues? ☐ Yes ☐ No ☐ Unknown	**If yes, please explain:**

Person is on: ☐ Parole ☐ Probation	Parole/Probation Officer:	Phone:
Other Pertinent Legal Information or Restrictions:		

10. FINANCIAL/INSURANCE INFORMATION		
Current Source of Income: ☐ SSI ☐ SSDI ☐ SDI ☐ WORK ☐ NONE ☐ UNKNOWN ☐ OTHER:		
Payee:	**Phone:**	
Current Insurance Status: ☐ Medi-Cal ☐ Medicare ☐ VA ☐ Private* ☐ Uninsured ☐ Unknown **Clients with Private Insurance may be subject to a Share of Cost*		
Medi-Cal #:	**Medicare #:**	
Private/Other Insurance Information:	**Policy #:**	**Phone:**

Save, attach and e-mail the completed form to sd_referralcenter@optum.com **using email encryption.**
This referral form should never be sent by email unless encrypted to ensure compliance to Article 14 and confidentiality.

SPOA ACT & SBCM USE ONLY	Referral ID: