# SISKIYOU COUNTY

**Health and Human Services Agency**

## REFERRAL FORM

*Please complete this section in its entirety*

Date: Client's Name: ID # (if applicable):

Age: DOB: SSN #: Phone #:

Address:

Parent, Guardian or Other Contact Person:

Relationship: Phone Number if Different from Client's:

Medi-Cal Client? Yes No Unknown, Member ID #: If not Siskiyou, County of Responsibility:

**REFERRING AGENCY** (check one)

Phone Number:

□ CPS/APS (check box and circle one)
  □ Linkages
□ Adult System of Care
□ Substance Use Disorders Program
□ CalWorks
□ Children's System of Care
□ BH Medical Support
□ Public Defender
  □ Mental Health Diversion Program
□ Probation
□ Remi Vista, Inc.: □ TBS □ Rehab □ IndTx □ PCIT
□ External Agency/Provider/Primary Care Physician
  Name:

**SERVICES REQUESTED** (check one)

□ Adult System of Care
□ Substance Use Disorders Program
  □ Parenting □ Life Skills
  □ Relapse Prevention
□ MH Groups
□ Self-Awareness Mental/Emotional Wellness
□ Children's System of Care
□ BH Medical Support
□ Remi Vista, Inc.: □ TBS □ Rehab □ IndTx □ PCIT
□ External Agency/Provider/Primary Care Physician
  Name:
  Phone Number:

Reason for Referral/Medical Necessity:

Diagnosis / Diagnostic Impression (if known):

Medications (if known):

Prescribing Physician(s):

Additional Information:

Person Making Referral: Phone Number:

**BHD STAFF:** Referral Accepted? ☐ Yes ☐ No Initial & Date: If no, give reason:

**BEHAVIORAL HEALTH DIVISION**

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