Mental Health Center Consultation Referral Form

Community Benefit

Please note that services are not guaranteed and subject to program requirements*

Referring Agency: _____

The referral is for: _____
Name

Date of Birth: _____ Age: _____

☐ Male ☐ Female

Family Members Names: Ages:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Address: _____

Phone (home): _____

Phone (cell): _____

Hours to contact: _____

Can a message be left: ☐ Yes ☐ No

Language spoken at home:

☐ English ☐ Spanish ☐ Other: _____

Does client have medical insurance?
(i.e. MediCal, Private insurance –Blue Cross, Kaiser, Aetna etc…)

☐ Yes, please refer to appropriate agency/behavioral health program through insurance

☐ No

Schools Children Attend: _____

Employment: _____

Is the potential client available in the morning?

☐ Yes ☐ No

Date Referred: _____

Check all that apply for the person being referred:

- ☐ Currently in crisis
- ☐ Difficulty fulfilling daily responsibilities
- ☐ Violent behavior ☐ past ☐ present ☐ suspected
- ☐ Alcohol abuse ☐ past ☐ present ☐ suspected
- ☐ Drug abuse ☐ past ☐ present ☐ suspected
- ☐ Domestic violence ☐ past ☐ present ☐ suspected
- ☐ Criminal behavior ☐ past ☐ present ☐ suspected
- ☐ History of suicide attempts

*** If person is currently a danger to him/herself or others, please call 911 or OC Health Care Agency at 714-850-8463 (Do not complete this form)

- ☐ Parenting difficulties
- ☐ Multiple life stressors
- ☐ Grief and loss
- ☐ Marital/relationship difficulties
- ☐ Symptoms of depression
- ☐ Symptoms of anxiety
- ☐ Health concerns: _____

Please list specific behaviors & symptoms that cause concern (reasons for referral):

Referring party's observations of client:

- ☐ Angry & loud ☐ Confused ☐ Frustrated
- ☐ Sad & tearful ☐ Cooperative ☐ Intimidating
- ☐ Hesitant or unwilling ☐ Desperate & in crisis
- ☐ Other observations: _____

Name of Referring Person: _____

Email: _____

Phone: _____

Did the potential client consent to services?

☐ Yes ☐ No

Other resources/referrals client was given:

Please email completed form to: CommunityMedReferrals@hoag.org or Fax to 949-631-8503

*A referral does not guarantee services. This referral is not intended to replace the services of a physician or psychiatrist, nor does it constitute a therapist-client relationship. Referrals will be screened based upon the program requirements; low income, uninsured, the patient's specific situation, as well as the mental health care provider's judgment. It is only after further discussion of the individual's specific situation, goals, risks and other relevant medical discussion that services may be provided.