INTENSIVE OUTPATIENT SERVICES REFERRAL FORM

Date of Referral:_____

Mental Health Services Client Referral

Individual's Name: _____ Social Security Number: _____

Individual's DOB: _____ Individual's Age: _____

Individual's Gender:_____ Individual's Preferred Language: _____

Caregiver Name: _____ Relationship to Individual: _____

Caregiver's Preferred Language:_____ Street Address: _____

City:_____ Zip Code: _____

Phone Number: _____ School Name/Grade: _____

Insurance Information

Medi-Cal Number: _____ Medi-Cal Issue Date: _____

Other: _____ _____

Referral Source

Contact Person: _____ Organization: _____

Phone Number: _____ Email Address: _____

Reason for Referral

Risk Factors

- ☐ Suicidal Ideation
- ☐ Recent Psychiatric Hospitalization
- ☐ Child Abuse/Neglect
- ☐ Homicidal Ideation
- ☐ Hallucinations/Delusions
- ☐ Self Harm (i.e. cutting, burning)
- ☐ Community Violence
- ☐ Odd Thinking/Behavior
- ☐ Other Trauma, please specify: _____
- ☐ Sexual Abuse
- ☐ Drug or Alcohol Use

Home Environment

- ☐ Recent Immigrant
- ☐ Family Violence
- ☐ Death/Loss
- ☐ Divorce/Separation
- ☐ Military-Connected Family
- ☐ Foster Home/Lives with Relative

School Performance

- ☐ Failing Grades
- ☐ Does Not Complete Assignments
- ☐ Speech/Language Concerns
- ☐ Performing Below Grade Level/Ability
- ☐ Known/Suspected Learning Disability
- ☐ Newcomer/School Adjustment Problems

Birth to Age 5

- ☐ Difficulty Separating
- ☐ Poor Emotional Regulation
- ☐ Problems with Sleep
- ☐ Problems Relating to Peers
- ☐ Delayed Language Development
- ☐ Wets/Soils Self
- ☐ Health Problems
- ☐ Temper Tantrums

Behavior/Social and Emotional Functioning

- ☐ Sadness/Depression
- ☐ Anxious/Nervous
- ☐ Withdrawn/Shy
- ☐ Disruptive/Defiant Behaviors
- ☐ Recent Weight Gain/Loss
- ☐ Impulsive/Hyperactive
- ☐ Aggressive/Tantrums
- ☐ Does Not Take Responsibility
- ☐ Truancy
- ☐ Poor Hygiene
- ☐ Sexualized Behavior
- ☐ Poor Social Skills

Other:

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Family Support Services

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