DEPARTMENT OF MENTAL HEALTH REFERRAL

FROM DEPARTMENT OF HEALTH SERVICES

Patient Information: ☐ HWLA – ID#: _____ ☐ L.A. Care (NONS/SPD) ☐ Other: _____

Name: _____ **DOB:** _____

Address: _____ **Phone #: ( ) _____ - _____**

Preferred Language:	☐ English	☐ Spanish	☐ Interpreter Needed	☐ Other:
Special Needs	☐ Wheelchair	☐ Visually-impaired	☐ Hearing-impaired	☐ Other:
Medical Diagnosis(es):	☐ Asthma	☐ CKD	☐ Hemorrhagic stroke	☐ Rheumatoid arthritis
	☐ Atrial fibrillation	☐ COPD	☐ Hypertension	☐ Smoking
	☐ BPH	☐ Crohn's disease	☐ IBS	☐ Ulcerative colitis
	☐ CAD	☐ Diabetes mellitus	☐ Ischemic stroke	☐ Other(1): _____
	☐ CHF	☐ Dyslipidemia	☐ Lupus	
	☐ Cirrhosis	☐ Fibromyalgia	☐ Osteoarthritis	☐ Other(2): _____
Psychiatric Diagnosis(es):	☐ Anxiety	☐ Depression	☐ Personality disorder	☐ Other: _____
(if known)	☐ Substance abuse →	☐ Alcohol	☐ Cocaine	☐ Marijuana

Name of Screening Tool (Indicate which screening used and attach to referral form)	**Score**	**Date of Administration**
☐ PHQ-2 ☐ PHQ-4 ☐ PHQ-9		
☐ Other:		

Current Med(s) – if available, attach print-out of current med(s): _____

Date Primary Care Provider discussed referral with patient: _____

Reason for Referral to Mental Health:

☐ Depression symptoms, but not suicidal, homicidal, or gravely disabled
"Gravely disabled" – unable to provide for his/her basic needs for food, clothing, or shelter due to a mental disorder

☐ Mood symptoms related to medical diagnosis(es) _____

☐ Anxiety symptoms ☐ Social stressors

☐ Schizophrenia ☐ Bipolar disorder

☐ Other (please explain):

_____

Referring Provider Information

Referring Location: ☐ **DHS Hospital:** _____ ☐ **ACN Health Center:** _____ ☐ **Community Partner:** _____

Referring Clinic Name: ☐ **Primary Care Clinic:** _____ ☐ **Specialty Clinic:** _____ ☐ **Other:** _____

Referring Provider Name: _____ **Date:** _____

Referring Provider Title: ☐ **MD** ☐ **DO** ☐ **NP** **Time:** _____ : _____ ☐ **AM** ☐ **PM**

Signature: _____

Medical Home Team Member Name & Title: _____ **Contact Number:** ( ) ____ - _____

For Co-located DMH Sites Only:

☐ Patient previously presented by "warm hand-off" to on-site DMH staff on _____ (date).

Submit completed form via RPS!

Patient Identification