MH-648B
Revised 06/11/14

REFERRAL RESPONSE OLDER ADULT FCCS
(FOR DMH USE ONLY)

Referral Source

Name of Referring Individual: _____

Agency Name: _____

Client Information **PATID#:** _____

Name: _____DOB: _____/_____/_____

Address: _____ City: _____ Zip :_____

Phone Number: _____SSN: _____ Race/Ethnicity: _____ Language: _____

Insurance**:** ☐ Medi-Cal ☐ Medicare ☐ Medi-Medi ☐ Indigent ☐ LACare ☐ HealthNet ☐ Beacon ☐ MHN

☐ Other _____

DMH Disposition

☐ Individual accepted for services – SMHS* Criteria Met ☐ Individual was denied for services – SMHS Criteria Not Met

☐ Individual declined DMH services ☐ Unable to contact Individual ☐ Client did not show up to appointment

General Findings: (include areas of identified need):

*Specialty Mental Health Services

Mental Health Diagnosis(es):

Psychiatric Medications (if prescribed by DMH):

Treatment Plan Overview (include barriers or complications if a focus of concern and type/frequency of intervention):

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure or use is prohibited without the prior written authorization of the individual/authorized representative to who it pertains unless otherwise permitted by law.

Print Name & Title of Responding Provider: _____

Signature: _____ Date: _____ Time: _____

Name of DMH Clinic: _____ Phone #: _____

Address: _____ City: _____ Zip: _____

OLDER ADULT FIELD CAPABLE CLINICAL SERVICES
REFRRAL RESPONSE

Original Copy –To Agency Initiating Referral
NCR – Retain by FCCS Program