COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

JUVENILE JUSTICE TRANSITION AFTERCARE SERVICES (JJTAS)
TREATMENT, REFERRAL AND AUTHORIZATION FORM

Email completed form to: jjtas@dmh.lacounty.gov

Referral to be completed by DMH staff only – 45 days prior to Transition MDT. Referrals only accepted via email above.

Referral Source			
Name:	**Title:**	**Phone:**	**Email:**

Client Information			
Client Name:		DOB:	
Race/Ethnicity:		Preferred Language:	
Gender:	☐ **Male** ☐ **Female**	Social Security Number:	
Insurance (if known):	☐ **Medi-Cal** ☐ **Health Families** ☐ **Private** ☐ **None** ☐ **Other:** ________________________		
Post-Camp Placement:			
Home Address:	**City:** **Zip Code:** **Phone:**		
Contact Person:		Telephone Number:	
Relationship to Client:			
Client is Emancipated Minor: ☐ No ☐Yes		Date of Emancipation:	

Name of Camp:		Camp Admission Date:	
Transitional MDT Date:		Projected Release Date:	Early Release Date:
DMH Camp Clinician:	**Phone:**	**Email:**	
Camp DPO:	**Phone:**	**Email:**	
Field DPO:	**Phone:**	**Email:**	

Other Agency Involvement			
☐ **DCFS**	**Contact Name:**	**Phone:**	**Email:**
☐ **Other:** _________________	**Contact Name:**	**Phone:**	**Email:**
☐ **Other:** _________________	**Contact Name:**	**Phone:**	**Email:**
☐ **Other:** _________________	**Contact Name:**	**Phone:**	**Email:**

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 is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Client Name: ________________

DMH IS#: ________________

PDJ#: ________________

Clinical Issues/Treatment Needs

Please check any that apply and provide details where space is provided:

- ☐ Depression
- ☐ Violence (i.e. home, gang, domestic violence, etc.)
- ☐ Substance use
- ☐ Child Welfare involvement (past or present)
- ☐ Family conflict
- ☐ Limited interpersonal, social and coping skills
- ☐ Impulsiveness
- ☐ Trauma (i.e., experienced, a threat, witnessed, etc.)
- ☐ Anxiety

Recommend:

- ☐ Family Functional Therapy (Family Therapy)
- ☐ Seeking Safety (Group Therapy)
- ☐ Aggression Replacement Therapy (Group Therapy)

☐ Medical (i.e., medication needs, mental health.):

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☐ Brief Overall Clinical Impression (i.e. symptoms, behaviors, strengths and impairments):

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M.H. and/or Substance Abuse Referrals Made Date Sent

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Court Mandated Treatment

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Date Received:		Received By:		Supervisor Assigned		Date:	
Clinician Assigned:		Date:	Initial Screening Date:	Location of Screening:			

Screening has been completed with the following recommendation:

- ☐ Client accepts JJTAS services
- ☐ Client declines JJTAS services
- ☐ Client accepts services; has been linked to the following agencies:

1. *Name of Agency:* ____________________ *Reason for linkage:* ____________________
   Contact Person: ____________________ *Title and Phone No:* ____________________
   Date of 1st appt: ____________________ *Memo:* ____________________

2. *Name of Agency:* ____________________ *Reason for linkage:* ____________________
   Contact Person: ____________________ *Title and Phone No:* ____________________
   Date of 1st appt: ____________________ *Memo:* ____________________

3. *Name of Agency:* ____________________ *Reason for linkage:* ____________________
   Contact Person: ____________________ *Title and Phone No:* ____________________
   Date of 1st appt: ____________________ *Memo:* ____________________

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