COUNTY OF LOS ANGELES-DEPARTMENT OF MENTAL HEALTH
SCHOOL THREAT ASSESSMENT RESPONSE TEAM (START)
REFERRAL FORM

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

If this is a psychiatric emergency, please call ACCESS Center 1-800-854-7771 or dial 911.

Please fax this form to (213) 402-3871 or e-mail START@dmh.lacounty.gov. **DATE:**

Name:		**DOB:**	**Age:**
Preferred Language:	**Secondary Language:**	**Ethnicity:**	**Gender: (Male / Female)**
Reason for Call:			
Referring Party Name & Contact:			
School Contacts (Name & Phone #):			**Grade:**
Student's Therapist:		**Phone #:**	
Treatment Agency:			
Current Psychiatric Treatment and Medications (List Names and other pertinent information such as compliance with meds):			
If Adult:	**Address:**		**Phone #:**
Guardian's Name:	**Address:**		**Phone #:**
Father's Phone:		**Mother's Phone:**	
Father's Address:		**Mother's Address:**	
Preferred Language:		**Preferred Language:**	

Primary Caregiver (Complete only if Biological Parent is not the Primary Caregiver)

☐ **Adoptive** ☐ **Guardian** ☐ **Foster** ☐ **Kinship/Relative** ☐ **Group Home** ☐ **Other**

Name:	**Relationship to Child:**		
Address:		**Phone:**	**Work:**
Length of Time with this Caregiver.			

(CHECK) Current Risk and Safety Concerns

Current Thoughts of Suicide	☐ **Yes**	☐ **No**	**Current Thoughts of Harming Another Person**	☐ **Yes**	☐ **No**
Suicide Plan	☐ **Yes**	☐ **No**	**Past Thoughts of Harming Another Person**	☐ **Yes**	☐ **No**
Past Thoughts of Suicide	☐ **Yes**	☐ **No**	**School Violence Plan**	☐ **Yes**	☐ **No**
Prior Suicide Attempts	☐ **Yes**	☐ **No**	**Has a Preoccupation with Violence**	☐ **Yes**	☐ **No**
Behavioral Problems in School	☐ **Yes**	☐ **No**	**Access to Weapons / Explosives**	☐ **Yes**	☐ **No**
IEP in Place	☐ **Yes**	☐ **No**	**Has a Hit List**	☐ **Yes**	☐ **No**
History of Bullying	☐ **Yes**	☐ **No**	**Has Injured Others**	☐ **Yes**	☐ **No**
History of Being Bullied	☐ **Yes**	☐ **No**	**Prior Psychiatric Hospitalization**	☐ **Yes**	☐ **No**
Violent Drawings/Writings	☐ **Yes**	☐ **No**	**History of Self Harm (Cutting)**	☐ **Yes**	☐ **No**
Recent Trauma Exposure	☐ **Yes**	☐ **No**	**History of Substance Abuse**	☐ **Yes**	☐ **No**
Victim of Violence/Abuse	☐ **Yes**	☐ **No**	**Current Substance Use/Abuse**	☐ **Yes**	☐ **No**
DCFS Involvement	☐ **Yes**	☐ **No**	**Truancy**	☐ **Yes**	☐ **No**
Probation involvement	☐ **Yes**	☐ **No**	**Suspensions**	☐ **Yes**	☐ **No**
Animal Cruelty	☐ **Yes**	☐ **No**	**Expulsions**	☐ **Yes**	☐ **No**
Fire Setting	☐ **Yes**	☐ **No**	**Media Research Behavior on the following**	☐ **Yes**	☐ **No**
Stalking Behavior	☐ **Yes**	☐ **No**	**(Explosives, Weapons, Terrorist Sites, School Shootings)**		
ERMHS	☐ **Yes**	☐ **No**			
ERICS	☐ **Yes**	☐ **No**			

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Any other details:

The content of this form contains protected and confidential information and must be adequately secured to prevent unauthorized access. Should you choose to email the document at the provided email address you are advised to take the necessary precaution.

PLAN/DISPOSITION (START OFFICE USE ONLY)		
IBHIS #/ Name:	☐ Returning Client	
Assigned to:	Date Assigned:	
Violent Risk Level: ☐High ☐Moderate ☐Low	Suicidal Risk Level: ☐High ☐Moderate ☐Low	
Status: ☐Consultation Only	☐Eligible/Activation	☐Cannot reach
☐Eligible/Decline/Follow-up	☐Not Eligible/Follow-up	☐Out of LA County
☐Eligible/Decline/No Follow-up	☐Not Eligible/No Follow-up	☐Gang-related
If the case is hospitalized: admit date and name of hospital:		
Reason of the Disposition:		
☐ **Referred to PMRT** ☐ **Referred to 911** ☐ **Referred to other services** ☐ **Other**		
Activation date **(For open and close cases that only receive crisis interventions H2011, no activation needed. But if cases are to be actively followed up, must activate)**		
Referral recorded by:	Record Date:	Date Received: