COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

CHILD/YOUNG ADULT (AGES 0-20)
FULL SERVICE PARTNERSHIP
REFERRAL FORM

REFERRAL INFORMATION

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.

AGE GROUP (check one): ☐ **FSP (ages 0-15)** ☐ **FSP (ages 16-20)** ☐ **IFCCS (ages 0-21)**

DATE: _____ **DMH IBHIS#** _____ **SSN:** _____

Last Name: _____ **First Name:** _____ **PREFERRED LANGUAGE:** _____

DOB: _____ **AGE:** _____ **RACE/ ETHNICITY** _____ **GENDER:** ☐ **M** ☐ **F** ☐ **OTHER**

CURRENT ADDRESS: _____ **CITY:** _____ **ZIP CODE:** _____

PHONE: _____ **CURRENT LIVING SITUATION:** ☐ **ESC** ☐ **TSC** ☐ **Home of Parent** ☐ **Relative**

☐ **Foster Home** ☐ **Group Home** **Facility Name:** _____ **Level:** _____

☐ **Other:** _____

INSURANCE: ☐ **Medi-Cal** ☐ **MCHIP** ☐ **Private** ☐ **None**

BENEFITS: ☐ **GR Recipient** ☐ **VA** ☐ **SSDI** ☐ **SSI** ☐ **Other Income**

PRIMARY CONTACT: _____ **RELATIONSHIP:** _____

PREFERRED LANGUAGE: _____ **PHONE:** _____

CONSERVATOR ? ☐ **YES** ☐ **NO** **NAME:** _____ **PHONE:** _____

All DMH Entities (DO and contracted) must submit the Referral Form via SRTS. For Non-DMH Entities, fax completed Referral form to the Impact Unit in your Service Area:

Service Area 1 Navigation Team
661-449-3704
Service Area 2 Navigation Team
213-652-1815
Service Area 3 Navigation Team
626-608-9086
Service Area 4 Navigation Team
213-947-4030
Service Area 5 Navigation Team
310-496-3266
Service Area 6 Navigation Team
323-978-6155
Service Area 7 Navigation Team
213-402-2309
Service Area 8 Navigation Team
562-684-4512

If referring to IFCCS, email completed Referral form to **CSOCIFCCS@dmh.lacounty.gov**

REFERRAL SOURCE

Individual's Name: _____

DMH IBHIS# _____

Agency: _____ Contact Person: _____

Phone: _____ Fax: _____ E-mail: _____

Is Individual currently receiving mental health services from your agency? ☐ YES ☐ NO

Other Agency Involvement: ☐ DCFS ☐ Probation ☐ DMH ☐ Regional Center ☐ START

Parole: ☐ Parolees* ☐ Post-Release Community Supervision/PRCS**
☐ CDCR# _____

***Eligible for FSP services. Must serve those who are Medi-Cal beneficiaries if they meet Specialty Mental Health Services (SMHS) criteria regardless of whether the beneficiary is currently receiving mental health services through the state parole system.**
****Not eligible for FSP services. Refer to AB 109 program by calling (213) 738-2877 or emailing DMHAB109-Coordinator@dmh.lacounty.gov**

☐ Client/Family is aware client has been referred to an FSP Program

If you are referring to IFCCS, please identify your portal:

☐ Child/YA FSP Navigator ☐ DMH WRAP Liaison ☐ DMH MAT ☐ EOTB
☐ DMH Hospital D/C Unit ☐ TSC ☐ SFC ☐ STRTP Aftercare
☐ Medical HUB

Please identify recent referrals: ☐ D-Rate ☐ Wraparound ☐ ISFC ☐ STRTP Aftercare
☐ Other: _____

DCFS INFORMATION

DCFS Case: ☐ **Adoption** ☐ **ER Case** ☐ **Family Maintainence/Reunification**
☐ **New Detention** ☐ **Voluntary Case**

Assigned DCFS Office: _____

CSW Name: _____ **Phone:** _____ **E-mail:** _____

SCSW Name: _____ **Phone:** _____ **Email:** _____

If you are a DCFS referring party, please attach the following documents:

☐ **Consents (179) Minute Order** ☐ **JV 220 (Current)** ☐ **Court Report/Voluntary Case Report**
☐ **Child Profile Report** ☐ **Placement History**

LEVEL OF SERVICE

Individual's Name: _____

DMH IBHIS# _____

Check ONE ONLY:

- ☐ Unserved (Not receiving mental health services)
  - ☐ History of mental health services, but none currently* ☐ No prior mental health services
- ☐ Underserved (Receiving some MH services, though insufficient to achieve desired outcomes)*
  - ☐ PEI ☐ Outpatient ☐ Other
- ☐ Inappropriately served (receiving some MH services, though inappropriate to achieve desired outcomes because of cultural, ethnic, linguistic, physical, or other needs specific to the client)*

If client is currently receiving mental health services please indicate:

Therapist: _____ Agency: _____ Phone: _____

*If client has received community-based mental health services within the last 6 months, (1) identify the program(s); (2) indicate the type and frequency of services; and (3) explain why the services are insufficient/inappropriate to achieve desired outcomes:

DIAGNOSTIC CONSIDERATIONS

DSM-5/ICD-10 Code: _____

Check All that Apply to Individual:

- ☐ Aggressive Ideation
- ☐ Aggressive Acts (by history or current)
- ☐ Aggressive Threats (by history or current)
- ☐ Fire Setting Ideation or Acts
- ☐ Inappropriate Sexual Ideation
- ☐ Contact with PMRT or Urgent Care
- ☐ Eating Disturbances
- ☐ Inappropriate Sexual Acts
- ☐ Psychiatric Hospitalizations (Indicate dates below)
- ☐ Suicidal Ideation/Attempts
- ☐ Symptoms of Psychosis
- ☐ Tarasoff Notifications (past or current)
- ☐ Exposure to Trauma
- ☐ Hyperactive/Impulsive/Inattentive
- ☐ Other _____

Provide Detail for Any Checked Items:

FOCAL POPULATION

Individual's Name: _____

DMH IBHIS# _____

CHECK APPROPRIATE REASON(S) FOR REFERRAL OF A CHILD OR YOUNG ADULT (AGE 0-21)WHO HAS A SERIOUS EMOTIONAL DISTURBANCE (SED):* AND AT LEAST ONE OF THE FOLLOWING:

Child/Young Adult zero to twenty one years old (0-21) experiencing one or more of the following:

- ☐ School absenses - considered chronically truant (missing 10% of school days within a year)
- ☐ School suspensions and/or expulsions
- ☐ Psychiatric hospitalization within the last six months
- ☐ History of suicidal and/or homicidal ideations
- ☐ Experiencing prodromal or first episode of psychosis
- ☐ Open LAC-Department of Children Family Services (DCFS) case
- ☐ Open LAC-Probation Department case
- ☐ Transitioning into the community from a restrictive setting
- ☐ Experienced two (2) or more placements due to behavioral health needs.
- ☐ Experiencing severe mental health issues and not engaging in mental health services
- ☐ Individual or family who lacks a fixed, regular, and adequate nighttime residence
- ☐ Experiencing co-occurring disorder

Provide Detail for Any Checked Items:

*"**Seriously emotionally disturbed"** means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 or Title 1 of the Government Code. [California Welfare and Institutions Code Section 5600.3]