MH-648A
Revised 06/11/14

REFERRAL TO OLDER ADULT FCCCS
(FOR DMH USE ONLY)

DMH Directly-Operated Clinics & Fax Numbers:

- ☐ Arcadia (626) 471-3575
- ☐ Augustus F. Hawkins (310) 668-4498
- ☐ Edmund D. Edelman (310) 915-8579
- ☐ GENESIS (213) 427-6161
- ☐ Long Beach (562) 218-0402
- ☐ Northeast (323) 344-8829
- ☐ Palmdale (661) 265-6025
- ☐ Rio Hondo (562) 402-3032
- ☐ San Pedro (310) 732-5809
- ☐ West Central (323) 292-0053
- ☐ West Valley (818) 598-6971
- ☐ Other: _____

Referral Information

PATID #: _____

Name: _____ DOB: _____/_____/_____

Address: _____ City: _____ Zip: _____

Telephone: _____ SSN: _____

Race/Ethnicity: _____ Preferred Language: _____

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

Is referral currently receiving any mental health services? ☐ Yes ☐ No

If yes, where and by whom: _____

Date discussed with individual: _____

Reason for Referral to Field Capable Clinical Services (please check reason(s) for referral and explain in the space below):

☐ Impaired access to mental health services requiring field-based services	☐ Homeless/risk of homelessness
☐ Isolated/homebound/limited or no support system	☐ Multiple recent hospitalizations
☐ Transitioning from one level of care to another	☐ Recent release from jail or risk of incarceration
	☐ Co-occurring disorders (mental, physical, substance, cognitive disorders)

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 and Title of Referring Individual: _____

Signature of Referral Individual: _____ **Date:** _____

Agency Affiliation: _____

Address: _____

May DMH contact you if additional information is required?
☐ Yes If yes, please list phone number: _____
☐ No

OLDER ADULT FIELD CAPABLE CLINICAL SERVICES REFERRAL

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