MH 673
Revised 09/13/10

JUVENILE JUSTICE TRANSFER SUMMARY

To be completed by Transferring Program:

TO: _____
Contact Person: _____

MHU Fax:
- ☐ **Central** (323) 226-8820
- ☐ **Los Padrinos** (562) 803-0637
- ☐ **Barry J. Nidorf** (818) 362-3446
- ☐ **Afflerbaugh** (909) 593-4750
- ☐ **CAU (Assessment Unit)** (818) 362-5781
- ☐ **Challenger** (661) 940-4089
- ☐ **Dorothy Kirby** (323) 269-2541
- ☐ **Gonzales** (818) 591-3311
- ☐ **Kilpatrick** (818) 991-8752
- ☐ **Munz/Mendenhall** (661) 724-1032
- ☐ **Miller** (818) 991-8752
- ☐ **Paige** (909) 593-4750
- ☐ **Rockey** (909) 971-0273 or (909) 394-0145
- ☐ **Scott/Scudder** (661) 296-3595
- ☐ **Other**: _____

FROM: _____
Contact Person: _____

MHU Phone:
- ☐ **Central** (323) 226-8826
- ☐ **Los Padrinos** (562) 940-6077
- ☐ **Barry J. Nidorf** (818) 364-2152
- ☐ **Afflerbaugh** (909) 593-4937 ext. 380
- ☐ **CAU (Assessment Unit)** (818) 364-2109
- ☐ **Challenger** (661) 940-4025
- ☐ **Dorothy Kirby** (323) 981-4301
- ☐ **Gonzales** (818) 222-1192
- ☐ **Kilpatrick** (818) 889-1353 ext. 348
- ☐ **Munz/Mendenhall** (661) 724-1213 ext.254
- ☐ **Miller** (818) 889-0260 ext 203
- ☐ **Paige** (909) 596-7484
- ☐ **Rockey** (909) 599-2391 ext.266
- ☐ **Scott/Scudder** (661) 297-1691
- ☐ **Other:** _____

IDENTIFIED PROBLEM AREAS:

☐ Adjustment Difficulties ☐ Suicide Risk ☐ Hyperactivity ☐ Sleep Disturbance ☐ Aggressive Behavior
☐ Thought Disturbance ☐ Anxiety ☐ Depression ☐ Substance Abuse ☐ Psychosis

Other/Comments:

SERVICES PROVIDED:

☐ Mental Health Screening ☐ Mental Health Assessment ☐ Crisis Intervention ☐ Individual Therapy
☐ Family Therapy ☐ Group Therapy ☐ Substance Abuse Counseling ☐ Medication

Other/Comments:

ATTACHMENTS (MENTAL HEALTH ONLY):

☐ MAYSI ☐ Child/Adolescent Assessment ☐ Psychotropic Medication Authorization ☐ Medication Notes
☐ CCCP ☐ COD ☐ Other

RECOMMENDATIONS:

To Be Completed by Receiving CAMP only:

New Primary Therapist: Name _____ Staff Code: _____

*Data Entry (to be completed by clerical staff):
New Primary Therapist entered in the IS by: _____ Date: _____

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 whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: _____ **IS#:** _____
DOB: _____ **PDJ#:** _____
Agency: _____ **Provider #:** _____

Los Angeles County – Department of Mental Health

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