COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

ADULTS (AGES 21 +)
FULL SERVICE PARTNERSHIP
REFERRAL FORM

CLIENT INFORMATION

AGE GROUP: (check one)

- ☐ ADULT 21-59
- ☐ ADULT 60+

***Insufficient details may delay referral process**

DMH IBHIS#: _____

DATE: _____ **SSN:** _____

LAST NAME: _____ **FIRST NAME:** _____ **PREFERRED LANGUAGE:** _____

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

CONTACT ADDRESS: _____ **CITY:** _____ **ZIP CODE:** _____

PHONE: _____ **CURRENT LIVING SITUATION:** _____

INSURANCE: ☐ MEDI-CAL ☐ MEDICARE ☐ NONE ☐ PRIVATE: _____

BENEFITS: ☐ GR RECIPIENT ☐ V.A. ☐ SSI ☐ SSDI ☐ OTHER INCOME:

☐ CLIENT SERVED IN THE MILITARY **CONSERVATOR?** ☐ YES ☐ NO **NAME:**

PHONE:

PRIMARY CONTACT:

PHONE:

RELATIONSHIP:

REFERRAL SOURCE

Agency: _____ Provider # (if applicable): _____ Service Area: _____

Contact Person: _____ Phone: _____ E-mail: _____

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

Other Agency Involvement: ☐ Probation ☐ ODR ☐ GR/DPSS ☐ Parole: ☐ Parolees*
☐ Public Guardian ☐ Regional Center ☐ Post-Release Community Supervision/PRCS**
☐ AOT ☐ APS 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**

If Individual was referred to any other programs, please identify:

☐ Client is aware that an FSP referral has been made on their behalf.

FOCAL POPULATION

Individual's Name: _____

DMH IBHIS#: _____

CHECK APPROPRIATE FOCAL POPULATION REASON(S) FOR REFERRAL:

	# Days during last 12 months	# Episodes in last 12 months
☐ Homeless		
☐ Jail		
☐ Institution(s) (mark all that apply):		
☐ Institution for Mental Disease		
☐ State Hospital		
☐ Psychiatric Emergency Services		
☐ Urgent Care Center		
☐ County Hospital		
☐ Fee for Service Hospital		

FOCAL POPULATION SPECIFIC TO AGE 60+

☐ **I**mminent risk for placement in a skilled Nursing Facility (SNF), Nursing Home or other institution

☐ Being released from SNF/Nursing Home Facility:

☐ Client has a recurrent history or is at risk of abuse or self-neglect and may be typically isolated (e.g. APS-referred clients)

☐ Older adult living independently who is unable to provide food for self, administer medications or is at risk for falls

☐ Physical health risk, serious or multiple chronic or acute physical health issues

Document any pertinent outreach information regarding client here and provide additional details for checked items: (Client is difficult to engage, client prefers female staff, language barriers, etc.

[1]An individual living anywhere outside, including on the streets, or any other location not meant for human habitation (e.g., in an abandoned building, vehicle, bus , etc.) or an individual prioritized by and/or assessed as homeless by DMH (e.g., on the Los Angeles County 5% list, identifies as highly vulnerable homeless through predictive rating scales, followed by a DMH homeless outreach team).

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)*
  - ☐ Outpatient ☐ PEI ☐ 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 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
- ☐ Other _____
- ☐ Inappropriate Sexual Acts
- ☐ Psychiatric Hospitalizations (Indicate dates below)
- ☐ Suicidal Ideation/Attempts
- ☐ Symptoms of Psychosis
- ☐ Tarasoff Notifications (past or current)

Provide detail for any checked Items, describe candidate's immediate risk, safety concerns and most concerning behavior that occurred including danger to self and others:

All DMH entities (directly-operated and contracted) must submit the Referral/Authorization Form via the Service Request Tracking System (SRTS). For Non-DMH entities, please fax the completed Referral/Authorization Form to the Impact Unit for 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
310-223-0695
Service Area 7 Navigation Team
213-402-2309
Service Area 8 Navigation Team
562-684-4512