Shasta County Mental Health
Psychiatric Referral Form
Fax (530) 225-5950 (Managed Care)

Print Form

Date: _____

Client Name: _____ CIN #: _____ DOB: _____

Chart #: _____ Gender ◯ M ◯ F

Parent/Guardian Name: _____ Telephone: _____

Address: _____

Primary Clinician Name: _____ Telephone: _____

Agency Name: _____ FAX: _____

◯ Yes ◯ No Does client have a current assessment and treatment plan?

◯ Yes ◯ No Does client have Medi-Cal?

◯ Yes ◯ No Is client a dependent of the court?

◯ Yes ◯ No Is child in Foster Care? County: _____

◯ Yes ◯ No Is child involved in a multi-agency program? Program name: _____

◯ Yes ◯ No Is the client enrolled in Day Treatment Program?

◯ Yes ◯ No Has client had a Juvenile Hall stay within the past 6 months?

◯ Yes ◯ No Has client displayed suicidal behavior within the past 6 months?

◯ Yes ◯ No Has client has crisis walk-in services within the past 6 months?

◯ Yes ◯ No Has the client been hospitalized within the last 12 months?

◯ Yes ◯ No Does the client display severe aggressive behavior?

◯ Yes ◯ No Does the client show significant evidence of psychotic behavior?

Current diagnoses:

PCP Name _____ Consulted with RE: Referral ◯ Yes ◯ No

Current medications:

Prescribed by _____

Current clinical status (include acuity and risk factors):

Signature of person making referral: _____ Date _____

Internal SCMH Use Only

Medical staff reviewer's recommedation:

☐ Refer to contract physician (must have Medi-Cal)

☐ Refer to Shasta County Mental Health physician

☐ Schedule Clinical Care meeting

Medication evaluation appointment: _____

Medical reviewer signature: _____