Health and Human Services Agency
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Children's Services
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Print Form
Clear Form

Children's Services
Referral for Medication Management

Chart Number: _____

Today's Date:_____ Name of Person Completing Referral Form:_____

PLEASE NOTE: Unless otherwise specified, your attendance at the Initial Medication Evaluation is strongly recommended in order to provide continuity of care and excellent collaboration.

CHILD'S INFORMATION

Child's Name:_____ Date of Birth:_____ Age:_____ Gender: ☐ Male ☐ Female

Lives with: ☐ Biological Family ☐ Foster Home ☐ Kinship Placement ☐ Adoptive Family ☐ Other: _____

Family Name: _____
(Provide first and last names of all caregivers)

Address:_____
(Street, Apt.#, City, State & Zip Code)

Main Phone: _____ Mobile Phone: _____ Work Phone: _____

Has this referral been discussed with the Legal Guardian(s) and client?: ☐ Yes ☐ No

CHILD WELFARE SERVICES INFORMATION – If Applicable

Caseworker's Name:_____ E-Mail Address:_____

Phone:_____Ext:_____ Mobile:_____ Fax:_____

Reason for Placement: _____

If this client is a foster youth, is there a previous JV220? ☐ Yes ☐ No If yes, please attach to this referral.

Please Note: If the client is a foster youth, it is beneficial for the Social Worker to be present or available by phone for the Initial Medication Evaluation in order to provide continuity of care and excellent collaboration. AND: Please have foster parents bring current prescription with them.

☐ Yes ☐ No Has this referral been discussed with the parent(s) and client?

☐ Yes ☐ No Does the client have Medi-Cal?

☐ Yes ☐ No Does the client have a PCP? PCP Name:_____ Consulted with RE: Referral: ☐ Yes ☐ No

☐ Yes ☐ No Is client in foster care? If yes, which County:_____

☐ Yes ☐ No Is client a dependent of the court? If yes, which county holds dependency?

☐ Yes ☐ No Has client been in a juvenile detention facility within the past 6 months? Date:_____ Location:_____

☐ Yes ☐ No Is client currently suicidal/homicidal or have they been within the past 6 months? Date:_____

☐ Yes ☐ No Has client had crisis walk-in services within the past 6 months? Date:_____ Location: _____

☐ Yes ☐ No Has the client been hospitalized within the last 12 months? Date:_____Location:_____

☐ Yes ☐ No Does client currently display severe aggressive behavior, or done so within the past 6 months?

☐ Yes ☐ No Does client currently display significant depression, anxiety or other symptoms that prevent them from participating in routine activities on a daily basis (i.e. is not attending school, unable to leave home, etc.)?

☐ Yes ☐ No Has the client received Psychiatric care in the past? If yes, Date:_____ Location:_____
If yes, please attach psychiatry care note from the last provider to this referral.

☐ Yes ☐ No Has the client had previous psychological or psycho educational testing? **If yes,** please attach copies to this referral.

☐ Yes ☐ No Is there an active IEP? If yes, please attach a copy to this referral.

Date of last medical exam: _____ Dr. Name: _____ Location:_____

Current presenting risk factors (include acuity, sx and bx):_____
_____
_____
_____

Current Diagnosis:_____

Current Medications: _____

The Referral behavior is present across which domains? ☐ Home ☐ Community ☐ Home

Add Any other pertinent history you would like th Psychiatrist to know: _____
_____
_____
_____

Current treatment goals:_____
_____
_____

Additional Information/Comments:_____
_____
_____

REFERRAL SOURCE INFORMATION

Relationship to Child:ψψ_____ψψψ Agency of Affiliation:_____

E-Mail Address:_____ Phone: _____ Ext: _____ Fax: _____

_____ _____ _____

Signature of person making the referral LPHA Credential/License Date

We appreciate your taking the time to complete this referral form. Please feel free to call with any questions regarding our services or for help in completing this referral form.

Completed Referrals should be faxed to:

HHSA Children's Services Outpatient at 530-225-3866 Attn: ***Office Support – Medication Mgmt Referral***

Internal Use Only					
Date Received: _____	Medication Evaluation Appointment:	Client			
Disposition: _____	_____	Chart #		DOB	

4/21/17