

# Mental Health Center Consultation Referral Form

Please note that services are not guaranteed and subject to program requirements\*

Referring Agency: _____	Date Referred: _____												
The referral is for: _____ <div style="text-align: center; font-weight: bold;">Name</div>	<b>Check all that apply for the person being referred:</b>												
Date of Birth: _____ Age: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Currently in crisis <input type="checkbox"/> Difficulty fulfilling daily responsibilities <input type="checkbox"/> Violent behavior <input type="checkbox"/> past <input type="checkbox"/> present <input type="checkbox"/> suspected <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> past <input type="checkbox"/> present <input type="checkbox"/> suspected <input type="checkbox"/> Drug abuse <input type="checkbox"/> past <input type="checkbox"/> present <input type="checkbox"/> suspected <input type="checkbox"/> Domestic violence <input type="checkbox"/> past <input type="checkbox"/> present <input type="checkbox"/> suspected <input type="checkbox"/> Criminal behavior <input type="checkbox"/> past <input type="checkbox"/> present <input type="checkbox"/> suspected <input type="checkbox"/> History of suicide attempts <small>*** If person is currently a danger to him/herself or others, please call 911 or OC Health Care Agency at 714-850-8463 (Do not complete this form)</small>												
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center;">Family Members Names:</td> <td style="width: 50%; text-align: center;">Ages:</td> </tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> </table>	Family Members Names:	Ages:	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Parenting difficulties <input type="checkbox"/> Health concerns: _____ <input type="checkbox"/> Multiple life stressors <input type="checkbox"/> Grief and loss <input type="checkbox"/> Marital/relationship difficulties <input type="checkbox"/> Symptoms of depression <input type="checkbox"/> Symptoms of anxiety
Family Members Names:	Ages:												
_____	_____												
_____	_____												
_____	_____												
_____	_____												
_____	_____												
Address: _____ Phone (home): _____ Phone (cell): _____ Hours to contact: _____ Can a message be left: <input type="checkbox"/> Yes <input type="checkbox"/> No Language spoken at home: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____ Does client have medical insurance? (i.e. MediCal, Private insurance –Blue Cross, Kaiser, Aetna etc...)	Please list specific behaviors & symptoms that cause concern (reasons for referral):   												
<input type="checkbox"/> Yes, please refer to appropriate agency/behavioral health program through insurance <input type="checkbox"/> No Schools Children Attend: _____  Employment: _____ Is the potential client available in the morning? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Referring party's observations of client:</b> <input type="checkbox"/> Angry & loud <input type="checkbox"/> Confused <input type="checkbox"/> Frustrated <input type="checkbox"/> Sad & tearful <input type="checkbox"/> Cooperative <input type="checkbox"/> Intimidating <input type="checkbox"/> Hesitant or unwilling <input type="checkbox"/> Desperate & in crisis <input type="checkbox"/> Other observations: _____  Name of Referring Person: _____  Email: _____  Phone: _____  <b>Did the potential client consent to services?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Other resources/referrals client was given:												

Please email completed form to: [CommunityMedReferrals@hoag.org](mailto:CommunityMedReferrals@hoag.org) or Fax to 949-631-8503

\*A referral does not guarantee services. This referral is not intended to replace the services of a physician or psychiatrist, nor does it constitute a therapist-client relationship. Referrals will be screened based upon the program requirements; low income, uninsured, the patient's specific situation, as well as the mental health care provider's judgment. It is only after further discussion of the individual's specific situation, goals, risks and other relevant medical discussion that services may be provided.