KINGS COUNTY
behavioral health

Behavioral Health Services Referral

460 Kings County Dr. Suite 101
Phone Number: (559) 852-2444 Fax: (559) 589-6928
Email: bhinfo@countyofkings.com

Date of referral: _____

Name of client: _____ **DOB**: _____ **Age**: _____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other **Does client identify as LGBTQ?** ☐ Yes ☐ No

Ethnicity: _____ **Race**: _____

Veteran: ☐ **Yes** ☐ **No**

Home Address: _____ **City**: _____ **ZIP**: _____

Mailing Address: _____ **City**: _____ **ZIP**: _____

Phone: (Home) _____ (Cell) _____ (Mess) _____

May we contact by: ☐ Mail ☐ Phone

Parent/Guardian (if minor):_____

If minor, can parent be contacted?	☐ Yes	☐ No	**Does client have an open CWS case?**	☐ Yes	☐ No
Interpreter Needed?	☐ Yes	☐ No	**Primary language**: _____		
Does the client have Medi-Cal?	☐ Yes	☐ No	**If yes, have they been referred to Kings View?**	☐ Yes	☐ No
Does the client have private insurance?	☐ Yes	☐ No	**If yes, were they referred to outside provider?**	☐ Yes	☐ No

REFERRAL FOR THE FOLLOWING SERVICES:

Children's System of Care (CSOC):

- ☐ **Individual Counseling:**
- ☐ **Parent Child Interactive Therapy (PCIT)(2-7 y/o)**
- ☐ **Skill Building Groups**
  Name of School: _____
- ☐ **Lifesteps (SARB Board Only)**

Adult System of Care (ASOC):

- ☐ **Individual Counseling:**
- ☐ **Collaborative Justice Treatment Court (Court/Probation Only)**
- ☐ **Veteran Support Group**

Is the client currently receiving Mental Health Services? ☐ **Yes** ☐ **No** **Diagnosis**_____**By Whom**_____

Did the client receive Mental Health Services in the past? ☐ **Yes** ☐ **No** **Diagnosis**_____**By Whom**_____

When_____

What recent changes have you noticed in the client?

☐ Changes in affects (moods/personality) ☐ Conflict resolution style ☐ School attendance
☐ School performance ☐ Social interactions ☐ Other: _____

Has the client recently experienced:

☐ Being Bullied ☐ Change in family dynamics – what changed? _____ ☐ CPS/Foster Care
☐ Justice system involvement: When/Why? _____ ☐ Loss of a loved one: Who/When? _____
☐ Physical/sexual abuse ☐ Other: _____

What kind of behaviors is the client currently displaying?

☐ Experimenting with alcohol and/or drugs ☐ Having suicidal thoughts ☐ Isolation or withdrawn
☐ Lack of interest in things they used to enjoy ☐ Previous suicide attempts When? _____
☐ Risky behavior Examples: _____ ☐ Sadness/depression
☐ Self harm Examples: _____ ☐ Uncharacteristic aggression

Other: _____

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Please provide more details for any of the above categories: _____

_____

_____

_____

Referring Agency/Party:_____ Referring Name: _____

Phone: _____ FAX: _____

Reason for referral: _____

_____

Referring party signature:_____ Date: _____

BH USE ONLY:

BH Services:

☐ Individual Counseling
☐ PCIT (2-7 years of age)
☐ School Skill Building Groups: _____
☐ Groups
☐ Lifesteps
☐ CJTC/Court Date: _____

☐ **Information Only, No referrals made, Date**:_____

☐ **Linkages: Other Agency**
Referral made to: _____ **I & R Date:** _____
Program referred to:_____

Agency Name_____**Date:**_____
Agency Name_____**Date:**_____
Agency Name_____**Date:**_____

Date Case Rec'd/Opened:_____**Assigned to:**_____**Anasazi Number:** _____