Client Meets/Needs Priority Admission Criteria: ☐

Referral Type: ☐ Children/Youth ☐ Adults
Mode of Entry ☐ Phone ☐ Walk-in ☐ Written

REFERRAL FORM

Date of Request:		**Information Taken By:**	
Last Name:		**First Name:**	
SSN:	**DOB:**	**Age:**	**Sex:** ☐ Male ☐ Female ☐ Unknown
(If minor, caregiver(s) name):		*Caregiver Primary Language:*	
(If minor, is this child in foster care?: ☐ Yes ☐ No		*Name of Social Worker:*	
Home Address:		**City:**	**ZIP:**
Mailing Address:		*City:*	*ZIP:*
Home Phone #:	**Cell Phone #:**	**Ok to leave message:** ☐ Yes ☐ No	

Primary Language at Home: ☐ English ☐ Spanish ☐ Hmong ☐ Lao ☐ Other:

Interpreter Needed? ☐ Yes ☐ No ***If yes, language*:**

Do you have a disability? ☐ Yes ☐ No ***If yes, explain*:**

Do you have an open CWS case? ☐ Yes ☐ No	**List ages of children under age 15:**
Are you currently a CalWORKs recipient? ☐ Yes ☐ No	**Number in Household** *(on income)***?**

Are you a Veteran? ☐ Yes ☐ No

Insurance Coverage: ☐ Medi-Cal ☐ Medicare ☐ Private Insurance ☐ Other: _____ ☐ None(Self-Pay)

Medi-Cal #:	**Medicare #:**

Person Making the Referral: ☐ Self ☐ Parent/Legal Guardian ☐ Other, *please specify*:

Primary Drug/Alcohol Problem:

Are you currently pregnant? ☐ Yes ☐ No *(If Yes, inform client of admission preference for pregnant women.)*

Do you have a child aged 1 year or less? ☐ Yes ☐ No *(If Yes and client is DMC, inform client of preference for post-partum women.)*

Have you used alcohol or drugs in the past 30 days? ☐ Yes ☐ No

Have you used needles to inject drugs in the past 30 days? ☐ Yes ☐ No	**In the past 12 months?** ☐ Yes ☐ No

Have you been diagnosed with Tuberculosis? ☐ Yes ☐ No

1a) Have you ever had life-threatening symptoms during withdrawal? ☐ Yes ☐ No

1b) Are you currently having similar withdrawal symptoms? ☐ Yes ☐ No

2) Do you have any current, severe, and untreated physical health problems? ☐ Yes ☐ No

3) Do you feel that you are imminently in danger of harming yourself or someone else? ☐ Yes ☐ No

✸ Yes to question 1a and 1b, and/or 3 requires the caller/client immediately receive medical or psychiatric care.

Have you had a physical exam from your primary care physician within the past 12 months? ☐ Yes ☐ No

✸ If you do not have a primary care physician, please let us know because we may be able to help you.

Date of physical exam:

If yes, may we request a copy of your physical exam from your primary care physician? ☐ Yes ☐ No

Client Signature: Date:

Primary Care Physician:	**Phone #:**	
Address:	**City:**	**ZIP:**

If no, please schedule a physical exam with your primary care physician as soon as possible.
✸ Have your primary care physician complete our **Physical Exam Form** and mail or fax it to:
Glenn County Behavioral Health, P.O. Box 1174, Orland, CA 95963, (530) 865-1146 (Phone)**, (530) 865-6483** (Fax)

Glenn County Behavioral Health Drug and Alcohol Services **REFERRAL FORM** *Page 1 of 2*	**Client Name:** **Client ID:**

CONFIDENTIAL PATIENT INFORMATION (SEE CALIFORNIA WELFARE AND INSTITUTIONS CODE SECTION 5328)

FOR OFFICE USE ONLY:

Section I. Referral Information

Financial Eligibility: (Check all that apply)
☐ AB 109 ☐ CalWORKs ☐ Medi-Cal ☐ None (Self-Pay)
☐ Private Insurance ☐ CWS Contract ☐ Medicare

Financial Eligibility Verified By:

Income Verified: ☐ Yes ☐ No | Date Verified:

Client has had a physical exam within the past 12 months. | Records requested on: | Records received on:

Client is eligible for pregnant or post-partum preference: ☐ Yes ☐ No *If YES, expedite admission.*

Comments:

Section II. Intake/Assessment

Intake/Assessment By: | Date Case Opened:

Date of First Appointment Offered: | Appointment Location: ☐ Willows ☐ Orland

Intake/Assessment Appointment Date: | Intake/Assessment Appointment Time:

☐ Outpatient Treatment ☐ Drug Court ☐ Juvenile Drug Court ☐ Prop 36 ☐ Perinatal ☐ CalWORKs

Section III. Assignment

Date Assigned:

Counselor:

NOTES:

Contact Log ID #

Glenn County Behavioral Health
Drug and Alcohol Services
REFERRAL FORM
Page 2 of 2

Client Name:

Client ID:

CONFIDENTIAL PATIENT INFORMATION (SEE CALIFORNIA WELFARE AND INSTITUTIONS CODE SECTION 5328)