Project FOCUS
Initial Referral Form

Please mail or fax this form to:

OCAPICA | 12912 Brookhurst Street Ste. 480, Garden Grove, CA 92840 | Ph: 714-636-6286 | Fax: 714-636-8354

CONFIDENTIAL INFORMATION

Referring Person or Agency: _____Date: _____

Phone # of Referring Person or Agency: _____

Participant's Name: _____ Male: _____ Female: _____

Participant's Phone #:_____Cell #:_____ Age: _____ DOB: _____

Participant's Address: _____

Participant's Parent / Guardian / Caregiver Name: _____

Parent / Guardian / Caregiver's Phone #: _____

Participant's **Language**: _____ Parent/Guardian/Caregiver's **Language**: _____

How many family members, including extended family are in the Participant's household? _____

Has Participant been notified/given consent that a FOCUS staff will contact them? Yes _____ No _____

What are the Participant's **immediate needs** (i.e. housing, food, therapy, medication, employment, etc)?

_____

_____

Other Comments (please use additional pages as needed):

_____

_____

Ethnicity
___ African-American
___ Asian
__Cambodian
__Chinese
__Korean
__Vietnamese
__Other:_____

___ Caucasian
___ Hispanic
___ Other: _____

Insurance
___ Medi-Cal
___ Private Insurance
___ None

Income Source
___ SSI, Disability or Pension
___ Employment
___ Cal Works, Unemployment
___ None
___ Other _____

What behaviors is the participant displaying or history indicative of severe mental illness? *(Circle all that apply)*
Hearing voices, social isolation, rapid speech, unprovoked anger, mood swings, suicide ideation/attempt, threatening others.
Other: _____

*If available, please fax assessment summary, MTP, CSP and Rehab Referral.

Diagnosis: (if available)
DSM 5/ ICD-10:

_____

_____

_____

_____

Substance Abuse
___ Unknown ___ No ___ Yes
Drug (s) of Choice: _____

Priority Target Groups
___ Homeless/Motel
___ Hx of multiple psych hosp
___ Unserved / Underserved because of linguistic or cultural isolation
___ First psychotic episode
___ Uninsured exiting SSA or probation system
___ With special needs and/or co-occurring disorders
___ Children of parents with serious mental illness
___ Children in danger of failing school.

Living Arrangements
___ Parent / Guardian
___ Homeless
___ Hotel
___ Apartment / R & B
___ Couch to Couch
___ Other: _____

For Office Use Only

Intake Therapist: _____ Date: _____

Program Director Signature: _____ Date: _____

PSC Assigned: _____ Therapist Assigned: _____ Date: _____

FSP approved at first face to face: _____ Date: _____