

# Initial Referral Form

## OCAPICA: Behavioral Health Services

**Please email or fax this form to: BehavioralHealthServices@ocapica.org**  
**12966 Euclid Street Ste. 495, Garden Grove, CA 92840 | Ph: 714-461-3687 | Fax: 714-591-5015**

Referring Person or Agency: \_\_\_\_\_ Date: \_\_\_\_\_

Phone # of Referring Person or Agency: \_\_\_\_\_

Participant's Name: \_\_\_\_\_ Gender Identity: \_\_\_\_\_

Participant's Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Participant's Address: \_\_\_\_\_

Do they have a Guardian or Conservator? Yes/No Guardian / Conservator Name: \_\_\_\_\_

Conservator/Guardian Phone #: \_\_\_\_\_ Do They Have An ID Card? Yes/No MediCal Card? Yes/No

Participant's Language: Limited English/Monolingual: \_\_\_\_\_ Bilingual: \_\_\_\_\_

How many family/extended members are in the Participant's household (if applicable)? \_\_\_\_\_

Has Participant been notified/given consent that program staff will contact them? Yes \_\_\_\_\_ No \_\_\_\_\_

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

**Other Comments** (please use additional pages as needed):  
 \_\_\_\_\_  
 \_\_\_\_\_

<p><b><u>Insurance</u></b>  <input type="checkbox"/> Medi-Cal  <input type="checkbox"/> Intensive Services Eligible  <input type="checkbox"/> Private Insurance  <input type="checkbox"/> None</p> <p><b><u>Income Source</u></b>  <input type="checkbox"/> SSI, Disability or Pension  <input type="checkbox"/> Employment  <input type="checkbox"/> Cal Works, Unemployment  <input type="checkbox"/> None  <input type="checkbox"/> Other _____</p> <p><b><u>Living Arrangements</u></b>  <input type="checkbox"/> Family /Guardian/ Conservator  <input type="checkbox"/> Homeless  <input type="checkbox"/> Hotel /Motel  <input type="checkbox"/> Apartment / R &amp; B  <input type="checkbox"/> Couch to Couch  <input type="checkbox"/> Other: _____</p>	<p><b><u>What behaviors is the participant displaying or history indicative of severe mental illness?</u></b> <i>(Circle all that apply)</i>                  Hearing voices, social isolation, rapid speech, unprovoked anger, mood swings, suicide ideation/attempt, threatening others.                  Other:                  _____                  _____</p> <p><b><u>Diagnosis:</u></b> <small>(if available)</small>  <b><u>DSM 5/ ICD-10:</u></b>                  _____                  _____</p>	<p><b><u>Priority Target Groups</u></b></p> <p><input type="checkbox"/> Unserved / Underserved because of linguistic or cultural isolation</p> <p><input type="checkbox"/> Homeless or at risk of homelessness</p> <p><input type="checkbox"/> Hx of multiple psych hospitalization</p> <p><input type="checkbox"/> Legal / Incarcerations or probation system</p> <p><b><u>Substance Abuse</u></b>  <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes</p>
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### For Office Use Only

Project SHINE-OC      Project RISE      MPOWER

Screening/Intake Therapist: \_\_\_\_\_ Date: \_\_\_\_\_

Program Administrator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PSC/CM Assigned: \_\_\_\_\_ Therapist Assigned: \_\_\_\_\_ Date: \_\_\_\_\_

Psychiatrist Assigned: \_\_\_\_\_ Specialist Assigned: \_\_\_\_\_ Date: \_\_\_\_\_

**For Self-Referral Participant with Medi-Cal or Potentially with Medi-Cal ONLY**

Medi-Cal Status: Certain or Uncertain (Circle that apply)      Type of Contact: Emergent    Urgent    Routine (Circle that apply)

Assessment Offered: \_\_\_\_\_ Date of Appointment Offered: \_\_\_\_\_ Date of Appointment Accepted: \_\_\_\_\_

Entered into Access Log By: \_\_\_\_\_ Date: \_\_\_\_\_

MRN: \_\_\_\_\_ FIN: \_\_\_\_\_