CONFIDENTIAL INFORMATION

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):

_____

_____

Insurance
___ Medi-Cal
___ Intensive Services Eligible
___ Private Insurance
___ None

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

Living Arrangements
___ Family /Guardian/ Conservator
___ Homeless
___ Hotel /Motel
___ Apartment / R & B
___ Couch to Couch
___ 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:

_____

_____

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

_____

_____

Priority Target Groups

___ Unserved / Underserved because of linguistic or cultural isolation

___ Homeless or at risk of homelessness

___ Hx of multiple psych hospitalization

___ Legal / Incarcerations or probation system

Substance Abuse

___ Unknown ___ No ___ Yes

For Office Use Only

☐ **Project SHINE-OC** ☐ **Project RISE** ☐ **MPOWER**

Screening/Intake Therapist: _____ Date: _____

Program Administrator Signature: _____ Date: _____ Date of First Psych Appt: _____

PSC/CM Assigned: _____ Therapist Assigned: _____ Date: _____ Date of First Tx Team Appt: _____

Psychiatrist Assigned: _____ Specialist Assigned: _____ Date: _____

For Self-Referred 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: _____