County of Yolo

Health and Human Services Agency

Karleen Jakowski
Mental Health Director

Tony Kildare, LCSW
Director, Child, Youth & Family Branch

MAILING ADDRESS
137 N. Cottonwood Street • Woodland, CA 95695
(530) 661-2945 • www.yolocounty.org

Children's Full-Service Partnership Referral Form

Name of Referring Person: ____ Date of Referral: _____ Agency Name:_____
Contact information: _____

Client Information

Client Name: _____
Address: _____

Telephone number: _____

Insurance/Financial Resources: SSI: ☐Yes ☐No ☐ Pending
Medi-Cal: ☐ Yes ☐No Number _____
Medicare: ☐Yes ☐ No Number _____
Other Financial Support: _____

Age: _____ DOB: _____ Ethnicity:_____
Gender: ☐ Male ☐ Female ☐ Other Preferred Pronouns: _____
Social Security Number: _____
Currently Homeless ☐Yes ☐ No
County of Residence: ☐ Yolo County ☐ Other County: _____
Reason for Other County Residence: _____

Emergency Contact/Next of Kin:_____
Name/relationship: _____ Phone number:_____
Case manager: ☐ Yes ☐ No Name:_____ Phone number: _____
Psychiatrist: ☐Yes ☐ No Name:_____ Phone number: _____
Primary Care Physician: ☐ Yes ☐ No, Name: _____

Diagnostic Information

Mental Health Diagnosis: _____

Describe Behavior and Risk Factors: What is the clinical picture at the time of the referral? What behavior(s) indicate the need for this level of care/mitigate the need for acute care?

_____

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Risk Factors

Assault:
Current Homicidal Ideation: ☐No ☐ Yes (describe): _____

Tarasoff Completed: ☐No ☐ Yes Identified Victim: _____
Contracting for Safety: ☐ N/A ☐ No ☐ Yes
Past threatening/assaultive behavior (describe): _____

Sexually dangerous risks and behaviors: _____
Inappropriate sexual behaviors: ☐ No ☐ Yes (if yes, then describe): _____

System Involvement:
On probation: ☐ No ☐ Yes Probation Officer name/phone #:_____

Foster youth/CWS Involved: ☐No ☐ Yes CWS SW name/phone #_____

Substance Abuse:
History of Substance Abuse: ☐ No ☐ Yes Substances used: _____
Active Detox or Withdrawal: ☐ No ☐ Yes
Substance use suspicions/involved in current presentation? ☐ No ☐ Yes
UTOX obtained: ☐ No ☐ Yes (results): _____

Medication/Medical Concerns

Current Medication(s): include standing medications and those administered at the referring agency:
_____
Medical problems: ☐ No ☐ Yes; Describe: _____
Allergies: ☐ Yes ☐ No Describe: _____
History of Psychiatric Hospitalization: ☐No ☐ Yes When/Where: _____
Other relevant medical information: _____

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CYF BH Team use only

Referral reviewed by: _____

☐ Referral Accepted Date referral sent to Provider: _____

☐ Referral Denied, reason: _____

_____

☐ NOABD Sent: ☐ Yes ☐ No