

# 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: \_\_\_\_\_

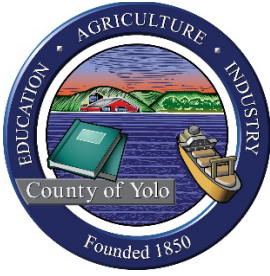
Primary Care Physician:  Yes  No, Name: \_\_\_\_\_

### 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