VENTURA COUNTY BEHAVIORAL HEALTH
Mental Health Services Referral Form

Please click email button to submit to: Access@ventura.org or fax to (805) 981-9268

CONSENT PAGE

Referral / Screening Source

Date of Referral: ____________ **Referring Person:** ____________ **Phone:** ____________ **FAX:** ____________

Email: ____________

Referring Agency:

- ☐ Hillmont Psychiatric Center
- ☐ Psychiatric Hospital: ____________
- ☐ Medical Provider: ____________
- ☐ Probation
- ☐ School: ____________
- ☐ STRTP/Residential Facility: ____________
- ☐ Housing Program/Board and Care: ____________
- ☐ VCBH Substance Use Services (SUS)
- ☐ Non-VCBH (SUS)Program: ____________
- ☐ Contracted Mental Health Provider Agency: ____________
- ☐ Other: ____________

Information of Individual

Last Name: ____________ **First Name:** ____________ **SSN:** ____________

Race:

☐ Alaskan Native ☐ Am. Indian ☐ Asian Native ☐ Black/African Am. ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian
☐ Hawaiian ☐ Korean ☐ Japanese ☐ Laotian ☐ Other Race (specify) ____________ ☐ Other Asian ☐ Samoan ☐ Vietnamese ☐ White

Ethnicity

☐ Cuban ☐ Mexican/ Mexican Am. ☐ Mixteco ☐ Non-Hispanic /non-Latinx ☐ Other Hispanic/Latinx (specify): ____________
☐ Puerto Rican ☐ Unknown

Primary Language:

☐ English ☐ Spanish ☐ Other: ____________ **DOB:** ____________ **Age:** ______ **Sex:** ☐ **M** ☐ **F** ☐ **Other** ____________

If relevant, Legally Authorized Representative (LAR) Name: ____________

(LAR) Relationship to individual: ____________ **(LAR) Primary Language:** ☐ English ☐ Spanish ☐ Other: ____________

Telephone: Home: ____________ **Cell:** ____________ **Work:** ____________

Address: ____________ **City:** ____________ **Zip:** ____________

Insurance Status: ☐ Medi-Cal# ____________ ☐ Medicare ☐ No Insurance ☐ Private Insurance: ____________

Special Status: ☐ Veteran ☐ Parolee ☐ Conserved ☐ Court dependent minor (CPS) ☐ Ward of the Court (Juv. Probation)

Name of the conservator/ Social Worker/ Probation officer: ____________ Phone: ____________

Consent for Referral Statement

☐ ***English Statement:*** I hereby give consent for Ventura County Behavioral Health (VCBH) to exchange and release information from this screening with an assigned VCBH provider, affiliated private provider or insurance carrier/Managed Care Plan (MCP) in order to evaluate me / my child for mental health services. I also authorize VCBH to update the referring party regarding the status of the referral. I understand that I will be contacted within 7 days by the assigned provider. If I have not been contacted within 7 days or am unsatisfied with the assigned provider, I will call (805) 981-4233.

☐ ***Spanish Statement:*** Doy mi consentimiento para que Ventura County Behavioral Health (VCBH) intercambie y divulgue información de esta breve evaluación con un proveedor asignado de VCBH, un proveedor privado afiliado o un asegurador/Plan de Atención Administrada para poder evaluar a mi / mi niño(a) para servicios de salud mental. También autorizo a VCBH proveer información con respecto al estado de la referencia a la agencia que hizo la referencia. Entiendo que el proveedor asignado me contactará en 7 días. Si no me han contactado dentro de los 7 días o no estoy satisfecho con el proveedor asignado, voy a llamar al (805) 981-4233.

____________ ____________
Individual Seeking Care Signature **Date**

____________ ____________
Legally Authorized Representative (LAR) Signature **Date**

Phone consent obtained from: ☐ Individual ☐ (LAR)

____________ ____________
Staff Signature (To verify phone consent obtained) **Date**

Reason for referral (required):

If individual is under 21 years old, please check all that apply:

- ☐ Has been exposed to trauma
- ☐ Is currently or has history of involvement in the Child Welfare System
- ☐ Is currently or has history of involvement in the Juvenile Justice System
- ☐ Is experiencing homelessness

Please Explain:

Risk factors: ☐ **Check if unknown**

☐	Thoughts of suicide or killing self	☐	Thoughts of hurting or killing others
☐	History of suicide attempt(s)	☐	History of assaulting others
☐	Current self-harm	☐	Auditory hallucinations telling them to hurt self or others
☐	History of self-harm	☐	Other

For any box checked, describe below:

Mental health history: ☐ Check if unknown

Currently receiving therapy? Currently seeing	☐ No	☐ Yes
a psychiatrist?	☐ No	☐ Yes
Currently assigned to a case manager? Prior mental	☐ No	☐ Yes
health treatment?	☐ No	☐ Yes
Has individual ever been in a psychiatric hospital?	☐ No	☐ Yes

If you checked any "yes" above, please explain (e.g., reason for services, provider names and dates of services if known):

Medical history: Check if unknown

Any physical health concerns? ☐ Unknown ☐ None ☐ Yes (explain below)

☐ TBI ☐ Dementia ☐ Developmental delay(s) e.g., Autism

Current psychiatric medications:

Name of medication	*Strength and frequency*	*Name of the prescriber*

Comments:

Substance use: ☐ Check if unknown

Type of Substance	Current Use	In Recovery	Date of last use
Alcohol	☐	☐	
Amphetamine/Methamphetamine	☐	☐	
Cocaine/Crack	☐	☐	
Marijuana, and Cannabis products, or Spice	☐	☐	
Hallucinogens	☐	☐	
PCP or Designer Drugs	☐	☐	
Inhalants	☐	☐	
Heroin	☐	☐	
Prescription Medication (e.g., pain medication)	☐	☐	
Over the counter medication (recreational use/ abuse only)	☐	☐	
Cigarettes, cigars, vaping, tobacco chew	☐	☐	
Other: ______________________________	☐	☐	

Areas of Impairment ☐ Check if unknown

Please indicate how symptoms listed above are impacting the following areas of impairment:

Work/Occupation (e.g., repeat job loss or inability to look for/apply for jobs due to symptoms/behaviors):

School/Academics (e.g., school expulsion, failing grades, missing multiple days of school due to symptoms/behaviors):

Activities of Daily Living (e.g., not showering, not taking medication, not completing chores, not driving/using public transportation due to symptoms/behaviors):

Social/Family Functioning (e.g., not able to maintain friendships, romantic or family relationships due to symptoms/behaviors, harming or attempting to harm others):

Developmental Milestones – children only:

Physical Health (e.g., repeatedly causing injuries or attempting to kill self, decline in physical health due to not seeking medical treatment/taking medications due to mental health symptoms/behaviors):

Living Arrangements (e.g., losing housing or being removed from family/home due to symptoms/behaviors):

Please feel free to attach additional sheets of paper with further explanation of individual's difficulties, struggles, symptoms, or any barriers they face in terms of accessing services.