San Luis Obispo County – Mental Health Services Act
Full Service Partnership
REFERRAL FORM

REFERRAL INFORMATION

DATE: _____ **CHART #_____**

SPECIFY ONE :

(□) CHILD/YOUTH (ages 0-17) **( ) TRANSITIONAL AGE YOUTH (ages 16-25)**

□

LAST NAME: _____ **FIRST NAME: _____** **PREFERRED LANGUAGE: _____**

DOB: _____ **RACE/ ETHNICITY: _____** **GENDER: □ M □ F** **LAST 4 DIGITS OF SSN#: _____**

ADDRESS: _____ CITY: _____ ZIPCODE: _____

PHONE : ( )_____ **CURRENT LIVING SITUATION: _____**

INSURANCE: □ MEDI-CAL □ HEALTHY FAMILIES □ CAL-WORKS □ AFDC
□ MEDICARE □ PRIVATE □ VA □ NONE

PRIMARY CONTACT: _____ RELATIONSHIP: _____

PREFERRED LANGUAGE/PRMARY CONTACT: _____ PHONE: ( ) _____

CONSERVATOR? □ YES (specify) _____ □ NO

REFERRAL SOURCE

Agency: _____ Contact Person: _____

Phone: ( ) _____ Fax: ( ) _____ Email: _____

Is the Individual currently receiving services from your agency? □YES (SPECIFY) □ NO

_____

Other Agency Involvement: □ DSS □ Probation □ Law Enforcement □ Other (Specify)_____

If Individual was referred to any other programs, please identify: _____

PLEASE FAX THE COMPLETED FORMS: REFERRAL FORM, INCLUSION/PRIORITY CRITERIA FORM, AND THE FORM TITLED "ADDITIONAL INFORMATION FOR FSP SERVICES" TO THE AREA OF THE COUNTY IN WHICH THE PERSON LIVES.
FOR NORTH COUNTY SEND TO PROGRAM SUPERVISOR, RAYMOND IREY, at FAX 461-6061. FOR ALL OTHER REFERRALS, SEND TO PROGRAM SUPERVISOR, JILL RIETJENS at FAX 781-1265.

Thank You