Shasta County Health & Human Services Agency | Children's Services Branch

Referral for Mental Health Services

Today's Date: _____ Chart Number: _____

Referring Organization: _____

Name of Referring Person:_____**Phone:**_____

Child's Name: _____Date of Birth: _____Age: _____ Gender: ☐ Male ☐ Female

Child's School: _____ Grade: _____

Lives with: ☐ Biological Family ☐ Foster Home ☐ Kinship Placement ☐ Adoptive Family ☐ Other: _____

Guardian Name(s): _____

Address: _____

Preferred Phone: _____ Alternate Phone: _____

Does Client have Medi-Cal? ☐ Yes ☐ No Medi-Cal CIN:_____

Is there an Active IEP? ☐ Yes ☐ No If so, please attach a copy to this referral.

Reason for Referral:

_____

_____

_____

_____

_____

Current Functioning (home, school, social interactions):

_____

_____

_____

_____

_____

_____

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_____

Has this referral been discussed with the parent(s) /guardian(s)? ☐ Yes ☐ No

I hereby authorize_____(referring agency) to exchange information with Shasta County Children's Mental Health for referral purposes only. I understand this referral is voluntary. By signing, I understand certain private health information about self or family may be releases to Children's Mental Health for the purpose of establishing services and verifying my child's Medi-Cal status. Should I decide services are not appropriate for self or family, I will notify Children's Mental Health and I understand that Children's Mental Health will destroy any private health information received from the referring agency.

Signature of Client/Legal Guardian _____ Date: _____

Print Name of Client/Legal Guardian _____

PLEASE FAX COMPLETED REFERRAL FORM TO (530) 225-3866, ATTENTION: KILEY CASTANEDA