Phoenix Houses OF CALIFORNIA

Child and Adolescent Mental Health Referral Form

Date of referral: _____

Name of client: _____ Date of birth: _____ Age: _____

Insurance type: ◯ Medi-Cal ◯ Private ◯ No insurance

Medi-Cal No. _____

Insurance provider name: _____ Card No. _____

Name of parent/caregiver: _____ Preferred language: _____

Telephone No. _____ Address 1: _____

Address 2: _____

Is the parent/caregiver aware that child is being referred for services with Phoenix Houses of California? ◯ Yes ◯ No

If not, please make sure to discuss with parent before submitting referral.

Referring Party

Name of referring party: _____ Title: _____

School/agency: _____ Contact No. _____

You will be contacted to confirm receipt of this referral.

Symptoms and Behaviors

- ☐ Sad/Depressed
- ☐ Tearful/Frequent Crying
- ☐ Nervous/Anxious
- ☐ Withdrawn
- ☐ Irritable
- ☐ Distracted
- ☐ Does not listen
- ☐ Does not follow rules
- ☐ Hyperactive
- ☐ Unmotivated
- ☐ Fighting/Physical Aggression
- ☐ Argues/Talks Back
- ☐ Does not complete work
- ☐ Suspended
- ☐ Thoughts of hurting self or others

Additional Information

How long have you observed symptoms/behaviors?

Other behaviors and comments:

Submit to Los Angeles County/Lake View Terrace

Office Use Only

Administrative Use: ◯ MHS ◯ MSS ◯ Intake ◯ RO

Intake date: _____

Comments: _____

_____

_____

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