CONTRA COSTA HEALTH SERVICES
CHILDREN’S MENTAL HEALTH DIVISION

REFERRAL FOR MENTAL HEALTH SERVICE
CHILDREN AND YOUTH

MENTAL HEALTH ACCESS LINE
Phone: (888) 678-7277
Fax: (925) 372-4422

For emergency services, refer to PES 925-646-2800

Date ____________________________

REFERRING PROVIDER (print) __________________________

Practice location __________________________

Person completing form __________________________  Contact # __________________________ Pager/VM/Phone

PATIENT NAME __________________________

PARENT/GUARDIAN NAME __________________________  Preferred Language __________________________

Phone #1 __________________________  Phone #2 __________________________  OK to leave a message?  □ Yes  □ No

Type of service requested  □ Medication  □ Psychotherapy/Counseling

□ Other: __________________________

Reason for Consultation __________________________

Medical History __________________________

Current Medications __________________________

Past Medications __________________________

Areas of Clinical Concern

<table>
<thead>
<tr>
<th></th>
<th>Mild</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention/Impulsivity/Oppositionality</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Socialization/Communication</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Depression</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Cognition/Memory/Thought problems</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Anxiety/Fears/Panic attacks</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Substance/Alcohol abuse</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Family relations</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>School attendance/Suspension</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

History of Significant Risk

<table>
<thead>
<tr>
<th></th>
<th>Recent</th>
<th>Past</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal thoughts or acts</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Behavior threatening/Dangerous to self/others</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Psychiatric hospitalization</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Threat of removal from home  □
Threat of removal to another home  □

DISPOSITION (To be completed by Access Line Staff)

□ Referral to county MH clinic/clinician: __________________________ Appt. Date/Time __________________________

□ Authorized/Referral to network providers. Parent/Guardian to call for appointment.

□ Consumer has referred to network providers. For questions, call 925-957-7239.

□ Unable to contact parent/guardian. Please refer to MH Access Line at 888-678-7277.

□ Other: __________________________

Disposition made by (print name): __________________________  Staff Phone number: __________________________

□ Information faxed to referring provider on (date): __________________________

PROVIDER’S RETURN FAX:

For all financial codes except:
CFS/Foster youth MediCal: Refer to CFS Social Worker
HO/Commercial CCHP and H9 Healthy Families: Refer to CCHP
(925) 957-7239

MR395 6-11
Children’s Mental Health Referrals

Date:

Dear Parent,

Your child has been referred to our Children’s Mental health program for counseling or support. Sometimes a child’s behavior can be improved by talking to a mental health counselor. This program can also assist your child if medications are needed for a mental health problem such as depression.

Please contact the Children’s Mental Health program as soon as possible to discuss your concerns about your child. They are available Monday – Friday between 8 am and 4:30 pm at:

**Children’s Mental Health Access Line: 1-888-678-7277**

All calls to this phone number are confidential. You will need:
- A quiet, private place to discuss your concerns
- Your child’s MediCal or Social Security number
- Your child’s date of birth

The counselors have interpreters if necessary. They will ask you a series of questions in order to decide who is the best doctor or therapist to help you with your child. If they are busy when you call, please wait and they will pick up the call as soon as possible.

[ ] Your doctor or nurse has made a written referral to the Access Line. A clinician at the Access line will attempt to contact you by phone when they receive this referral. Please give your doctor the best contact information so that the Access line can reach you during the day.

Thank you.