**CONTRA COSTA HEALTH SERVICES**  
**CHILDREN’S MENTAL HEALTH DIVISION**

**REFERRAL FOR MENTAL HEALTH SERVICE**  
**CHILDREN AND YOUTH**

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

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

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**Date**  
**REFERRING PROVIDER (print)**  
**Practice location**

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**Person completing form**  
**PATIENT NAME**

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**Phone #1**  
**Phone #2**  
**OK to leave a message?**  
- Yes  
- No

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**Type of service requested**  
- Medication  
- Psychotherapy/Counseling  
- Other: ____________

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**Reason for Consultation**

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**Medical History**

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**Current Medications**

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**Past Medications**

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

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**History of Significant Risk**  
<table>
<thead>
<tr>
<th>Recent</th>
<th>Past</th>
<th>Recent</th>
<th>Past</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal thoughts or acts</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Behavior threatening/Dangerous to self/others</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other: __________________</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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**Psychiatric hospitalization**  
- ☐  
- ☐

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**DISPOSITION (To be completed by Access Line Staff)**

- ☐ Referral to county MH clinic/clinician: __________________ Appt. Date/Time __________________
- ☐ Authorized/Referred to network providers. Parent/Guardian to call for appointment.
- ☐ Consumer has commercial CCHP. Request faxed to CCHP. For questions, call 925-957-7239.
- ☐ Unable to contact parent/guardian. Please refer to MH Access Line at 888-678-7277.
- ☐ Other: __________________

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Disposition made by (print name)  
Staff Phone number

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Information faxed to referring provider on (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.