

Instructions for Completing a Referral to the VCBH Provider Network

Making the referral

- STEP 1** Complete the information on the Consent Page and the Screening form.
- STEP 2** Have the guardian/adult client read and sign the consent for referral statement on the Consent Page in the appropriate language: A client cannot be referred without consent.
- STEP 3** Fax the completed Consent Page AND Screening form to the appropriate program, listed below.

What happens next?

- STEP 4** VCBH completes the Follow-Up form to triage and assign the referral to a an appropriate provider, which may be a VCBH program or contract provider.
- STEP 5** The assigned provider informs the referring party about the disposition of the referral.

If you need assistance with a referral, an update regarding the referral process, or to provide more information regarding the referral, please contact the Clinic Administrator or Officer of the Day (OD) from the appropriate program, listed below. Thank you for your patience!

<i>Dependency care youth</i>	<i>Young adults (18 to 23)</i>
Child Welfare Subsystem	VCBH Transitions Program
Fax 289-1676	Fax 981-9271
Phone 289-3383	Phone 982-9270

For all other referrals

Oxnard Options	Ventura Options	Santa Paula Options	Conejo Options	Simi Options
Fax 981-8461	Fax 289-3395	Fax 933-0057	Fax 777-3574	Fax 582-7514
Phone 981-8460	Phone 289-3100	Phone 525-1618	Phone 777-3505	Phone 582-7507

CONSENT PAGE

Referral/Screening Source

Referring person: _____ **Telephone No.:** _____

Referring agency: Public Health CFS Vista Del Mar Probation
School: _____ First 5: _____
VCMC program: _____ Other: _____

Date of referral: _____ **E-Mail Address:** _____ GroupWise

Client Information

Last name: _____ **First name:** _____ **MI:** _____ **Sex:** M F

Ethnicity: Latino Caucasian African American Other _____

Primary Language: English Spanish Other: _____ **Date of Birth:** _____

Current Residence: Shelter Care Relative(s) Biological Parent(s) Juvenile Justice Facility
Foster Care Residential Treatment Facility Other _____

Current Services: Early Start Head Start Special Education Public Health First Five TBS
Regional Center CFS: Worker's Name/Number: _____
Probation: Officer's Name/Number: _____ Other: _____

Insurance Status: Medi-Cal # _____ Healthy Families No Insurance
Other: _____

Caregiver/Contact Name: _____ **Relationship to Youth:** _____

Caregiver Primary Language: English Spanish Other: _____

Telephone: Home _____ Work _____ Cell _____

Address: _____ **City:** _____ **Zip** _____

English Statement: I hereby give consent for Ventura County Behavioral Health (VCBH) to exchange and release information from this screening with an assigned VCBH provider or affiliated private provider in order to evaluate me / my child for mental health services. I understand that I will be contacted within 7 days by the assigned provider. If I have not been contacted within 7 days or am unsatisfied with the assigned provider, I will call (805) _____.

Spanish Statement: Por la presente doy consentimiento para que Ventura County Behavioral Health (VCBH) intercambie y de información de esta breve evaluación a un proveedor de VCBH asignado o proveedor privado afiliado para poder evaluar a mi / mi niño(a) para servicios de salud mental. Yo entiendo que se van a poner en contacto conmigo en menos de 7 días para asignar a un proveedor. Si no se han puesto en contacto conmigo en 7 días o menos o si no estoy satisfecho con el proveedor asignado, voy a llamar al (805) _____.

Parent/Guardian Signature Date

Client Signature Date

SCREENING FORM

Urgent & Emergency Questions

Quests for 18 Months old to Adult

1. Danger to self or others in the last 30 days (Reckless, talks of hurting self or others, assaulting, animal cruelty, put self in danger, self-injurious, fearless, etc.)? Yes No Unknown
2. Bizarre/unusual behavior in the last 30 days (hallucinations, smears feces, severe toileting problems, paranoid, talks to self, wanders house at night, repetitive movements/vocalizations, preoccupation with routines or objects, self-stimulating behavior, excessively accident prone, etc.)? Yes No Unknown
3. Immediate need for medication consult or refill? Yes No Unknown
4. Experienced/witnessed abuse, violence, trauma, or neglect in the last 30 days? Yes No Unknown
5. Behaviors placing current living, educational, or childcare situation in jeopardy (excess non-compliance, daily outbursts, frequent arrests, needs supervision, excess truancy, property destruction, impulsive/disruptive, constantly challenging caregiver, etc.)? Yes No Unknown

Routine Questions

1. History of above behaviors more than 30 days ago? Yes No Unknown

List: _____

2. Difficulty managing emotions (persistent arching, floppiness or stiffening when held; inconsolable; severe temper outbursts/tantrums; excess worry; sleeping problems or nightmares; overactive; hopeless, sad, withdrawn, or cries frequently)? Yes No Unknown

Quests for 0 to 5 years old

3. Disconnected, excessively passive, or withdrawn (feeding problems; unresponsive to caregivers or environment; doesn't vocalize, cry, or smile; delayed language; doesn't play or interact with others; withdrawn; loss of previous skills, etc.)? Yes No Unknown

Quests for 18 months old to Adult

4. Social adjustment problems (damages property of self or others, runs away, lack of guilt or concern for others, steals, fights, mute, etc.)? Yes No Unknown

Quests for 6 years old to Adult

5. Problems making and maintaining healthy relationships (poor peer relationships, poor bond with caregiver, gang involved, provokes & victimizes)? Yes No Unknown
6. Personal care problems (poor hygiene, wets/soils self, eats non-food items, etc.)? Yes No Unknown
7. Significant functional or daily living problems (significant language delays, can't manage age appropriate skills, difficulty sleeping, difficulty understanding others, etc.)? Yes No Unknown
8. Known to abuse alcohol and/or drugs? Yes No Unknown

Medical issues: _____

Reason for referral/comments: _____

Case Disposition (completed by clinician)

Status Routine No case made (why: _____)
 Urgent: Must offer the client/family an appointment that occurs within the next 24 hours
 Emergency: Immediate intervention
Referrals Centralized Screening Other: _____
Interventions Contact police Contact CIRT Parent informed about CIRT CFS report - date _____
Other: _____

Triage (completed by centralized screening team)

Refer out Provider Network: _____ Access line
 NFL: _____ Client's private insurance
 Other: _____
Refer in (VCBH) Clinic/Prog.: _____ Psychiatrist: _____
 Clinician: _____ Other: _____
Other referrals VCMC Med Clinic Healthcare for Kids Pub. Health Regional Center
 United Parents Other: _____

Outreach Information (completed by VCBH/contractor staff as referral is processed)

Date of first contact with clinic: ___/___/___
Date screen completed: ___/___/___
Clinician appt: Date 1st available ___/___/___ Physician appt: Date 1st available ___/___/___
Clinician appt: Date 1st made ___/___/___ Physician appt: Date 1st made ___/___/___
Clinician appt: Date 1st seen ___/___/___ Physician appt: Date 1st seen ___/___/___
If VCMC referral, date results sent to physician ___/___/___

Outreach attempts: _____

Final disposition: _____

Comments: _____

Ventura County Behavioral Health Confidential Patient Information Welfare & Institutions Code 5328 and Evidence Code 1014	Youth & Family Interagency Screening Follow-Up	Name: ID#: Site #:
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