Alameda County Behavioral Health

Confidential Patient Information
See Welfare & Institution Code 5328

REFERRAL TO FSP (UNIVERSAL ACBH FORM)

ALL REFFERRALS ARE APPPROVED BY ACCESS

Date: _____

☐ Urgent (Felony 13701) –check box if applicable

Name of Person Submitting Request: _____

Name of FSP and/or Service Team: _____

Phone Number: _____

Client Information:

Name: _____ Soc.Sec. # / InSyst #: _____

Date of Birth: _____ Gender: _____ Ethnicity: _____

Primary Language: _____

Insurance Info: Medi-Cal ☐ Medicare ☐ Other: _____ ☐

Income Sources: SSI ☐ SDI ☐ Social Security ☐ Pension ☐ Other ☐

Psychiatrist: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Significant Other: _____ Phone: _____

Living Situation (Address or if Homeless, where client can be found):

_____

Phone: _____

Type of Housing: _____

WHAT AGENCIES AND OTHER RESOURCES ARE INVOLVED?

☐ Transitional Housing Placement (THP)/ Transitional Housing Placement-Plus (THP+) For Transition Age Youth (TAY) _____

☐ CASE MGMT: _____

☐ HOUSING: _____

☐ MENTAL HEALTH: _____

☐ LEGAL: _____

□ OTHER: _____
WHAT DOES THE CLIENT WANT AND NEED:

□ HOUSING □ GROUPS □ MEDICATION SUPPPORT □ CASE MANAGEMENT
□ VOCATIONAL TRAINING □ TO CONTINUE EDUCATION □ OTHER

_____

PLEASE DESCRIBE REASON FOR REFERRAL TO FSP (CIRCUMSTANCES, AND EXPERIENCE ON SERVICE TEAM (If applicable) :

_____
_____
_____
_____

CURRENT LEVEL OF SOCIAL/INTELLECTUAL FUNCTIONING & DAILY LIVING SKILLS:

_____
_____
_____
_____

STRENGTHS, SUPPORTS & FAMILY INVOLVEMENT:

_____
_____
_____
_____

STATUS OF BENEFITS & APPLICATION FOR ADULT SSI:

_____
_____
_____

Brief Clinical Summary of Issues, including hospitalizations, incarcerations, deterioration in functioning (highlight need for services requested-see criteria):

_____
_____
_____
_____
_____
_____
_____
_____
_____

Has the client been informed of this referral request? _____

Clinician's name and contact information: _____

Supervisor's signature for approval of request: _____

Send Referral Packet to ACCESS

FSP PROGRAMS

C/o ACCESS
Behavioral Health Care Services
2000 Embarcadero Cove, Suite 205
Oakland, CA 94606

Fax: (510) 346-1083

QIC Code: 22707

Please include the following documents with your referral:

Referral Packet Contents

- Completed Referral Form
- Completed ACBH Screening Tool
- MHS 140 Face Sheet
- Most recent psychiatric evaluation, including medication list, history and physical and lab reports
- Copy of current recovery plan
- Copy of most recent clinical evaluation (psychosocial history), including progress notes
- Copy of MediCal card if available

For Office Use Only:

Disposition: ☐ Accepted for _____ faxed to _____ on _____

Disposition: ☐ Not accepted for _____ faxed to _____ on _____

Denied because

_____

_____

_____