ALCOHOL, DRUG & MENTAL HEALTH SERVICES
DON KINGDON, PH.D, INTERIM DIRECTOR

**Fax completed form to: (888) 625-5503
Radawn Alcorn, TAY System of Care (510) 567-8199 or
TATReferrals@acgov.org**

PLEASE ATTACH ADDITIONAL CLINICAL INFORMATION TO THIS FORM – PSYCH EVALS – HOSPITAL INTAKES- DISCHARGE NOTES AND ANY OTHER RELEVENT DOCUMENTATION. THANK YOU.

CLIENT NAME: ______________________________

BIRTH DATE: ____________ AGE________ REFERRAL DATE:__________

SSN: ____________________ CLIENT #: ______________

ADDRESS: ______________________________

____

PHONE NUMBER: ______________________________

REFERRED BY

YOUR NAME: ______________________________

AGENCY:______________________________

PHONE: ______________________________

FAX: ______________________________

CLIENT CONTACT INFORMATION: ______________________

WHY REFERRING TO TAT?

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CURRENT DIAGNOSIS & SUPPORTING SYMPTOMS- PLEASE INCLUDE DIAGNOSIS ON ALL AXIS AND GAF:

AXIS I: ____________________ AXIS IV: ____________________

AXIS II: ____________________ AXIS V: ____________________

AXES III: ____________________ GAF: ____________________

LIST MEDICATION & COMPLIANCE:

____

____

____

PRESCRIBING MD: ____________________ NEXT APPOINTMENT DATE: ____________________

HOSPITALIZATION HISTORY: (PLEASE ATTACH ADDITIONAL PAGES IF NEEDED)

DATE: ____________ REASON: ____

DATE: ____________ REASON: ____

DATE: ____________ REASON: ____

SUBSTANCE ABUSE: (DRUG OF CHOICE? HOW LONG? FAMILY HISTORY?)

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____

SELF-HARM HISTORY:

____

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____

CRIMINAL/VIOLENCE HISTORY:

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WHAT HAS BEEN DONE TO HELP TRANSITION CLIENT TO ADULT MENTAL HEALTH SERVICES?

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CURRENT LIVING SITUATION (IF ENDING, WHY & WHEN? WHERE WILL CLIENT LIVE IN NEXT 6 MONTHS?):

____

____

____

EDUCATION ❑ GRADE COMPLETED ______ ❑ HIGH SCHOOL DIPLOMA ❑ GED ❑ CERTIFICATE OF COMPLETION

❑ COLLEGE DEGREE: ________ ❑ OTHER CERTIFICATIONS/ TRAINING: ____________________

WHAT ARE THE CLIENT'S EDUCATION, VOCATION AND/OR CAREER GOALS?

____

____

____

HAS THE CLIENT BEEN IN FOSTER CARE? ❑ YES ❑ NO

JURISDICTION: ______________________ CWW: ______________________

PLEASE DESCRIBE THE CLIENT'S FOSTER CARE CIRCUMSTANCES AND EXPERIENCE:

____

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____

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

____

____

____

STRENGTHS, SUPPORTS & FAMILY INVOLVEMENT:

____

____

____

STATUS OF BENEFITS & APPLICATION FOR ADULT SSI:

____

____

DOES THE CLIENT HAVE INSURANCE? ❑ YES ❑ NO

IF SO, WHAT KIND? ❑ MEDICAL ❑ PRIVATE: ______________ ❑ OTHER: ______________

WHAT AGENCIES AND OTHER RESOURCES ARE INVOLVED? ❑ THP/ THP + ❑ CASE MGMT: ______________

❑ HOUSING: ______________ ❑ MENTAL HEALTH: ______________

❑ OTHER: ______________

WHAT DOES THE CLIENT WANT AND NEED:

❑ HOUSING ❑ GROUPS ❑ MEDICATION SUPPPORT ❑ CASE MANAGEMENT

❑ VOCATIONAL TRAINING ❑ TO CONTINUE EDUCATION ❑ OTHER ______________

____

WHAT IS THE CURRENT DISCHARGE PLAN? ______________

____

____

THE TAT COMMITTEE MAY CALL FOR MORE INFORMATION OR MAKE AN APPOINTMENT FOR YOU TO PRESENT TO THE COMMITTEE ON WEDNESDAYS, BETWEEN 10:30 A.M. AND 12 NOON. PLEASE ATTACH ANY SUPPORTING DOCUMENTATION YOU MAY HAVE ON THE CLIENT'S MENTAL HEALTH HISTORY (I.E. PSYCHOSOCIAL ASSESSMENTS, PSYCHOLOGICAL EVALUATIONS, DISCHARGE SUMMARIES, ETC. PLEASE DISCUSS WITH RADAWN ALCORN, LCSW THE BENEFITS OF INVITING OTHER PROFESSIONALS CURRENTLY PROVIDING SERVICES TO THE CLIENT, I.E. STAFF FROM SOCIAL SERVICES, AB3632, PROBATION, REGIONAL CENTERS. BE PREPARED TO DISCUSS A BREIF PSYCHOLOGICAL HISTORY, EDUCATIONAL STATUS/ AB 3632 HISTORY, DEVELOPMENTAL ISSUES, THE CLIENT'S LIFE GOALS, AND CURRENT TREATMENT AND DISCHARGE PLANS. THANK YOU.