Referral Form
Prevention and Early Intervention Program

Patient Name: ___________________________ **Medical Record#** ___________________

Primary Language (circle one): English Spanish Other: ___________________________

Date of birth: ___________________________ **Phone #:** ___________________

Address: ____

Referring Provider (name/title): ___________________________ **Date:** ______________

Primary care location: ___________________________ **Phone:** ___________________

Circle one: Medi-Cal Self Pay Insurance

Reason for referral:

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Current Rx medications (or attach copy):

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Please have patient sign upon referral

I understand that ☐I am / ☐my child is being referred to Ventura County Behavioral Health for an evaluation for behavioral health services. These services may include individual and/or group therapy and/or psychiatric consultation. I hereby give my consent for the exchange and release of information for this purpose.

Entiendo que ☐yo / ☐mi hijo(a) ha sido referido al programa para la Prevención y Intervención Temprano, para una evaluación de la salud mental y los servicios que posiblemente podemos utilizar. Estos servicios pueden incluir terapia individual y / o terapia de grupo y / o consulta psiquiátrica. Doy mi consentimiento para el intercambio y divulgación de la información contenida aquí para este propósito. Este programa es proporcionado por el Condado de Ventura Behavioral Health.

___________________________ ___________________

Patient/ Parent/Guardian Signature **Date/Fecha**
Firma del Paciente/Padres/Guardian

Behavioral Health Use Only

PEI clinician response back/outcome: **(BH/PEI use only)**

Patient participating in BH/PEI services (indicate group and/or individual therapy services):

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- ☐ **Referred to BH STAR (screening, triage, assessment& referral) program for psychiatric assessment/services.**
- ☐ **Patient declined to participate in BH services**
- ☐ **Unable to contact patient/patient was a no show to two scheduled appointments/patient missed two scheduled appointments and did not reschedule**
- ☐ **Patient currently enrolled in another BH program:** ___________________________