

Referral Form:
VCMC to VCBH

Making the referral

- 1) Complete the attached form and obtain the necessary consent from the patient or Guardian. Please formulate a clear referral question (what is the question you want us to answer).
- 2) Please fax the completed form and any relevant additional information to STAR.

What happens to the referral?

- 1) The referral will be reviewed by STAR to determine whether the client meets criteria for VCBH mental health services.
- 2) The client will be contacted within 3 business days (non-urgent referrals) or 1 business day (urgent referrals) after receiving the referral to schedule an appointment for the initial psycho-social assessment with a clinician. If the client does not meet criteria for VCBH mental health services, the client will be provided with alternative referrals. Please note that STAR could also refer clients to specialized programs that are provided by contracted mental health providers.
- 3) A letter will be send to the referring clinic/physician indicating whether the client is accepted for services with VCBH or was referred out.

Information on VCBH services

- 1) VCBH serves clients who have a serious mental illness. In other words, their functioning in the community/school/work/at home is significantly affected by their mental illness.
- 2) VCBH does not serve clients whose symptoms is primarily the result of:
 - Substance abuse (please contact ADP for relevant services)
 - Mental Retardation (please contact Tri-County Regional Center for services)
 - Autism (please contact Tri-County Regional Center for services)
 - Dementia, including Alzheimer's (please refer to a Neurologist)

If you need assistance with a referral, an update regarding the referral status, or to provide more information regarding the referral, please contact the Clinic Administrator or Officer of the Day (OD) at the STAR Program office phone number below. Thank you for your collaboration!



STAR Program
1911 Williams Drive, Suite 165
Oxnard, CA 93030
Phone 805-981-4233 (Reception)
Fax 805-981-9268
1-866-998-2243 (24/7 Access/Crisis Line)

VCMC to VCBH REFERRAL

Referral Source

Referring Clinic: _____ Date of Referral: _____

Referring Person (Name & Title) _____ Phone No.: _____

Primary Care Physician (If different from above) _____

Client Information

Last name: _____ First name: _____ SS# _____

Ethnicity: Latino Caucasian African American Other _____ Sex: M F

Primary Language: English Spanish Other: _____ Age: _____ Date of Birth: ____/____/____

If relevant, Parent/Caregiver Name: _____ Relationship to Client: _____

Parent/Caregiver Primary Language: English Spanish Other: _____

Telephone: Home _____ Cell _____ Work _____

Address: _____ City _____ Zip _____

Insurance Status: Medi-Cal # _____ Healthy Families ACE No Insurance Private Insurance
 Medicare

Special Status: Conserved Court dependent minor (CPS) Ward of the Court (Juv Probation)

Name and contact number of Conservator/ Social Worker/ Probation office: _____

Referral Information

Reason for Referral:

Safety/Risk Issues (check if client are either currently presenting with these symptoms or in the last 6 months)

Suicidal Thoughts/Statements Homicidal Thoughts/Violent Behaviors Hallucinations/Delusions Fire-setting
 Property destruction Unable to take care of basic self-care needs

Current Medication: _____

Other Relevant Information (medical conditions, stressors, substance use): _____

Consent for Referral Statement

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) 981-4233.

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) 981-4233.

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Phone consent obtained from client parent/guardian

Staff Signature (To verify phone consent obtained) _____ Date _____

Client is aware of referral Yes No