



**College Community Services
Adult Referral Form for Counseling Services**

Client Information	Date of Referral: (required)		Cerner Number: _____ (office use only)		
	Referral Agency: <input type="checkbox"/> School <input type="checkbox"/> Primary Physician <input type="checkbox"/> Probation <input type="checkbox"/> Self/Parent <input type="checkbox"/> Other _____				
	Contact Person at referral site:		Telephone:		
	Referral Type: <input type="checkbox"/> Call-in <input type="checkbox"/> Fax <input type="checkbox"/> Walk-in <input type="checkbox"/> Transfer/Other: _____				
	Name:		DOB:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> TGI	
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> TGI				
	Address:		City:	Zip Code:	
	Telephone/Message Number:		Alternative Number:		
	Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other				
	Insurance: <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Medi-Cal with Kern Family Health Care <input type="checkbox"/> Other/Private				
Reason For Referral (Please check appropriate)	Behavior/Mood	Work/School Performance	Home situation		
	<input type="checkbox"/> Depressed/Sad <input type="checkbox"/> Withdrawn/Isolative <input type="checkbox"/> Irritable <input type="checkbox"/> Nervous/anxious <input type="checkbox"/> Aggressive/angry <input type="checkbox"/> Poor Concentration <input type="checkbox"/> Impulsive <input type="checkbox"/> Sleep Increase/Decrease <input type="checkbox"/> Interrupts/disrupts others <input type="checkbox"/> Paranoia <input type="checkbox"/> Delusions <input type="checkbox"/> Hallucination <input type="checkbox"/> Crying <input type="checkbox"/> Hits/bites <input type="checkbox"/> Self-harming behavior <input type="checkbox"/> Alcohol/Drug Use	<input type="checkbox"/> Tardy/poor attendance <input type="checkbox"/> Short attention span <input type="checkbox"/> Inattentiveness <input type="checkbox"/> Learning difficulties <input type="checkbox"/> Incomplete assignments <input type="checkbox"/> Fighting <input type="checkbox"/> Suspensions <input type="checkbox"/> Work performance issues <input type="checkbox"/> Disciplinary actions <input type="checkbox"/> Terminations	<input type="checkbox"/> Separation <input type="checkbox"/> Divorce <input type="checkbox"/> Step family <input type="checkbox"/> Foster Care <input type="checkbox"/> Adopted Social environment changes <input type="checkbox"/> Deaths <input type="checkbox"/> Births <input type="checkbox"/> Family/friend moved <input type="checkbox"/> Housing issues <input type="checkbox"/> Financial issues <input type="checkbox"/> Legal issues		

Other Information: _____

Identified Risk

- Has the individual been a danger to him/herself or to others in the last 90 days?**
 Yes No Unknown
- Does individual currently have any thoughts, plans or intent to commit suicide?**
 Yes No Unknown
- Does individual currently have any homicidal thoughts, plans or intent?**
 Yes No Unknown

CCS Taft Clinic
1021 4th Street, Suite B
Taft, CA 93268
Tel: 661-765-7025
Fax: 661-765-7045

CCS Tehachapi Clinic
113 East F Street
Tehachapi, CA 93561
Tel: 661-822-8223
Fax: 661-823-9347

CCS Lake Isabella Clinic
2731 Nugget Ave.
P.O. Box 2632
Lake Isabella, CA 93240
Tel: 760-379-3412
Fax: 760-379-5332

CCS Mojave Clinic
16940 Hwy. 14, Suites C-J
Mojave, CA 93501
Tel: 661-824-5020
Fax: 661-824-5026

CCS Ridgecrest Clinic
1400 N. Norma St., Ste. 127-133
Ridgecrest, CA 93555
Tel: 760-499-7406
Fax: 760-499-7479



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OFFICE USE ONLY
CONTACT ATTEMPT:

1ST _____ **RESPONSES** _____ **INITIAL** _____

2ND _____ **RESPONSES** _____ **INITIAL** _____

3RD _____ **RESPONSES** _____ **INITIAL** _____

Letter sent _____

THIS TRANSMISSION CONTAINS CONFIDENTIAL AND PRIVILEGED HEALTH INFORMATION THAT IS PROTECTED FROM MISUSE AND UNAUTHORIZED DISCLOSURE BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, THE REGULATIONS PROMULGATED THEREUNDER, AND OTHER APPLICABLE STATE LAWS (COLLECTIVELY, "THE LAWS"). VIOLATION OF THE LAWS MAY RESULT IN CIVIL AND/OR CRIMINAL PROSECUTION AND/OR THE IMPOSITION OF MONETARY PENALTIES. THE INFORMATION CONTAINED IN THIS TRANSMISSION IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY TO WHICH IT IS ADDRESSED. IF THE READER OF THIS OF THIS MESSAGE IS THE INTENDED RECIPIENT, OR THE EMPLOYEE, OR AGENT RESPONSIBLE FOR THE DELIVERING THE MESSAGE TO THE INTENDED RECIPIENT YOU ARE HEREBY NOTIFIED THAT ANY USE, DISCLOSURE, DISSEMINATION, DISTRIBUTION OR COPYING OF THIS TRANSMISSION AND THE INFORMATION CONTAINED HEREIN ARE STRICTLY PROHIBITED AND UNLAWFUL. IF YOU HAVE RECEIVED THIS TRANSMISSION IN ERROR, PLEASE NOTIFY THE PRIVACY OFFICER OR ASPEN EDUCATION GROUP IMMEDIATELY BY CALLING TOLL-FREE (888) 97-ASPEN AND KINDLY RETURN THE ORIGINAL TRANSMISSION VIA THE U.S. POSTAL SERVICE ADDRESSED TO: ASPEN EDUCATION GROUP, 1777 CENTER COURT DRIVE, SUITE 300, CERRITOS, CA 90703, ATTN: PRIVACY OFFICER.

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Outcome Results:

Assessment Date: _____ **Referring Party Informed:** **Yes** **No** **Date:** _____

Qualified **Not Qualified**

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