College Community Services
Adult Referral Form for Counseling Services

Client Information

Date of Referral: (required)	Cerner Number: _____ (office use only)	
Referral Agency: ☐ School ☐ Primary Physician ☐ Probation ☐ Self/Parent ☐ Other _____		
Contact Person at referral site:	Telephone:	
Referral Type: ☐ Call-in ☐ Fax ☐ Walk-in ☐ Transfer/Other:_____		
Name:	DOB:	Sex: ☐ Male ☐ Female ☐ TGI
Sex: ☐ Male ☐ Female ☐ TGI		
Address:	City:	Zip Code:
Telephone/Message Number:	Alternative Number:	
Preffered Language: ☐ English ☐ Spanish ☐ Other		
Insurance: ☐ Medi-Cal ☐ Medi-Cal with Kern Family Health Care ☐ Other/Private		

Reason For Referral (Please check appropriate)

Behavior/Mood

- ☐ Depressed/Sad
- ☐ Withdrawn/Isolative
- ☐ Irritable
- ☐ Nervous/anxious
- ☐ Aggressive/angry
- ☐ Poor Concentration
- ☐ Impulsive
- ☐ Sleep Increase/Decrease
- ☐ Interrupts/disrupts others
- ☐ Paranoia
- ☐ Delusions
- ☐ Hallucination
- ☐ Crying
- ☐ Hits/bites
- ☐ Self-harming behavior
- ☐ Alcohol/Drug Use

Work/School Performance

- ☐ Tardy/poor attendance
- ☐ Short attention span
- ☐ Inattentiveness
- ☐ Learning difficulties
- ☐ Incomplete assignments
- ☐ Fighting
- ☐ Suspensions
- ☐ Work performance issues
- ☐ Disciplinary actions
- ☐ Terminations

Home situation

- ☐ Separation
- ☐ Divorce
- ☐ Step family
- ☐ Foster Care
- ☐ Adopted

Social environment changes

- ☐ Deaths
- ☐ Births
- ☐ Family/friend moved
- ☐ Housing issues
- ☐ Financial issues
- ☐ Legal issues

Other Information: _____

Identified Risk

1. **Has the individual been a danger to him/herself or to others in the last 90 days?**
   ☐ Yes ☐ No ☐ Unknown
2. **Does individual currently have any thoughts, plans or intent to commit suicide?**
   ☐ Yes ☐ No ☐ Unknown
3. **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_____

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Outcome Results:

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

☐ **Qualified** ☐ **Not Qalified**

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