College Community Services Referral Form

(Office Use Only) MediCal#: ________________

Client Information

Date of Referral: (Required) | AZ 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 of Client: | DOB: | Age:

Sex: ☐ Male ☐ Female | Social Security Number:

Address: | City: | Zip Code:

Telephone/Message Number: | Alternative Number:
Preferred Time to Call:

Preferred Language: ☐ English ☐ Spanish ☐ Other: _________________

Does the child have: ☐ Medi-Cal ☐ Medi-Cal with Kern Family Health Care ☐ Other/Private: ______________

Name of Parent: | Legal Guardian/Foster Parent:

Parent Signature: (Required)

School Information

School Name: | Special Ed: ☐ Yes ☐ No | Grade:
ERMS: ☐Yes ☐ No

Teacher: | Telephone: | Fax No:

Other Agencies/Services Involved:
☐ School Psychologist ☐ AB/Wraparound ☐ Kern Regional Center ☐ Probation ☐ Social Worker ☐ School Counselor
Name:

Reason for Referral (Optional)

School/Work Performance

- ☐ Tardy/poor attendance
- ☐ Poor work performance
- ☐ Learning disability
- ☐ Low interest/motivation
- ☐ Poor Concentration
- ☐ Incomplete work
- ☐ Numerous fights
- ☐ Short attention span
- ☐ Suspensions

Behavior/Mood

- ☐ Aggressive/angry/hits
- ☐ Short temper
- ☐ Impulsive
- ☐ Low self-worth
- ☐ Seeks attention
- ☐ Steals/lies
- ☐ Withdrawn/Isolative
- ☐ Anxious/nervous
- ☐ Sad/depressed/
- ☐ Erratic behavior
- ☐ Disrupts others
- ☐ Daydreams
- ☐ Paranoia
- ☐ Delusions
- ☐ Hallucination
- ☐ Self-Harming behavior
- ☐ Alcohol/Drug Use

Home situation

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

Social environment changes

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

Other Information: ____

CCS Wasco (Child)
29325 Kimberlina Rd.
Wasco, CA 93280
Tel: 661-758-4029
Fax: 661-758-0891

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

CCS Tehachapi
113 East F Street
Tehachapi, CA 93561
Tel: 661-822-8223
Fax: 661-823-347

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

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

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

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Identified Risk

1. Has the individual been a danger to him/herself or to others in the last 90 days?
   ☐ Yes ☐ No ☐ Unknown
2. Has the individual been hospitalized in the last 90 days?
   ☐ Yes ☐ No ☐ Unknown
3. Does individual currently have any thoughts, plans or intent to commit suicide?
   ☐ Yes ☐ No ☐ Unknown
4. Does individual currently have any homicidal thoughts, plans or intent?
   ☐ Yes ☐ No ☐ Unknown
5. Service Delivery Preferences: _______Home _______Office _______Other

OFFICE USE ONLY

CONTACT ATTEMPT:

1ST _____________ RESPONSES_________________________________ INITIAL___________

2ND _____________ RESPONSES_________________________________ INITIAL___________

3RD _____________ RESPONSES_________________________________ INITIAL___________

☐ 10-day letter sent on ______________

Outcome Results: ____

Referring Party Informed: ☐ Yes ☐ No Date: ______________

Service:	Date:	(2nd Date:)	(3rd Date:)
Intake			
Assessment			
Treatment Plan			
First Time Service			

OFFICE CHECKLIST

☐ Info Note
☐ Registered in Cerner
☐ Scheduler (Therapist & RC)
☐ Ran Medical – If NO, explain: ____
☐ Entered Client into CSI Log 1st Offer: ______________ 2nd Offer: ______________
☐ Disposition Letter ☐ Letter Faxed – Date: ___________ ☐ No Disposition Letter Required

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