Referral Form

Our Safe Place
3427 4th Ave
San Diego, CA 92103
Phone: 619.525.9903
Fax: 619.525-9908
Website: www.sdyouthservices.org

Please fax completed form to our clinic at the number listed above (no cover sheet necessary). If you have any questions about our services, please refer to our brochure or contact our clinic.

Potential Clients Info

Legal Last Name	Legal First Name	Legal Middle	Ok to contact parent/guardian?
Preferred Name		Gender	Gender Pronoun
Address		Phone Number(s)	Ok to leave VM?
Social Security #		Email	Date of Birth

Please select applicable coverage potential client has:
☐Medi-Cal Policy ID:_______________
☐Other Coverage Name of Insurance:_______________ Policy ID:_______________
☐No Coverage

Parent/Legal Guardian Info

Legal Last Name	Legal First Name	Preferred Language	Email Address
Address ☐ Same as potential client		Relationship to Client	Phone Number(s)
Legal Last Name	Legal First Name	Preferred Language	Email Address
Address ☐ Same as potential client		Relationship to Client	Phone Number(s)

Potential client interested in receiving services? ☐Yes ☐No
Parent/legal guardian interested in participating in services? ☐Yes ☐No

Is Parent/Legal guardian aware of identity/orientation? ☐Yes ☐No
Is Parent/Legal guardian supportive of identity/orientation? ☐Yes ☐No

Referral Info and Consents

Reason for referral/additional information:

☐ Youth is at risk for emergency psychiatric hospitalization as one possible treatment option, though not necessarily the only treatment option **or** Youth has had at least one emergency psychiatric hospitalization in the past 24 months.
Date of hospitalization: _______________
☐ Early signs of psychosis If yes, please specify: _______________

Please check all appropriate symptoms:
☐auditory/visual hallucinations ☐angry/argumentative ☐sad/depressed ☐anxious ☐threat to others ☐threat to self
☐learning disability ☐inattentive ☐disruptive ☐declining grades ☐truancy ☐low self-esteem ☐social problems ☐withdrawn/isolates
☐alcohol/substance abuse ☐runaway ☐divorce/separation ☐identity/orientation ☐coming out ☐suicidal thoughts/attempts

Referring person's Name / Organization / Phone / Email:

Date of Referral:

Potential client's signature and date:

Parent's / legal guardian's signature and date:

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For Office Use Only

SP #: _____________

Date Attempted: ___________________ Outcome: ____

Date Attempted: ___________________ Outcome: ____

Date Attempted: ___________________ Outcome: ____

Date Attempted: ___________________ Outcome: ____

Reason Youth/Family Did Not follow through: ____

Intake Appointment Date/Time/Location: ____

Assigned Staff: ______________________________

Referral Source Updated On: ____________________________