

Adult Behavioral Wellness Referral Form

**Referring Party Information:**

Date of Referral: ___ / ___ / ___ Name of Person Making Referral: _____
Referring Program: _____
Program Referred To: _____ Phone Number: (____) _____
Signature of Person Completing Referral: _____ Print Name: _____

Identifying Information of Person Being Referred:

Name: _____
DOB: ___ / ___ / ___ Clinician's Gateway Consumer ID: _____
Gender: _____ Language Preference: _____
Address: _____ Phone: (____) _____

Clinical Information: *Reason for Referral*

Functional Impairments (Housing/Employment/Legal/ADL/Interpersonal Challenges): _____

of Psych Hospitalizations in Last 2 Yrs: _____ Reasons: _____
Problematic Use of Substances? Yes / No Drug of Choice: _____ Last Use: _____
Risk of Harm / Dangerous Propensities (e.g., Suicidal/Homicidal Attempts): Yes / NO

Diagnoses / Authorizations / Pertinent Dates:

Primary Diagnosis: _____ Secondary Diagnosis: _____
Date Health History Questionnaire Completed: ___ / ___ / ___ Date of Most Recent Assessment: ___ / ___ / ___
Date of Most Recent Treatment Plan: ___ / ___ / ___ Date of Most Recent Treatment Authorization: ___ / ___ / ___
MORS Rating Score & Date: _____

Medical Issues / Medications:

Primary Care Physician: _____ Phone Number: (____) _____

Legal Information:

Is the Person Conserved? _____ Name of Conservator: _____ Phone: (____) _____
Is there a history of incarceration and/or Legal Issues? YES / NO
Person is on: Probation / Parole Probation Officer: _____ Phone: (____) _____
Other Pertinent Legal Information or Restrictions: _____

Financial / Insurance Information:

Current Source of Income: SSI / SSDI / Work / Other: _____
Does this person have a Payee? Yes / No Name of Payee: _____
Current Insurance Status: Medi-Cal / Medi-Care / Indigent / Other: _____

To be Completed by Recipient of Referral:

Date Received: ___ / ___ / ___ Staff Contacted Person on: ___ / ___ / ___ Was Person Admitted? Yes / No
If No, Why? _____
Admission Date: ___ / ___ / ___ Primary Case Manager: _____
Referring Program Informed of Disposition: Yes / No / Date: ___ / ___ / ___
Referral Form Returned to Be-Well Supervisor: Yes / No

For Additional Information about the disposition of this referral, please contact Quality Care Management: (805) 681-4908.