North County San Diego Interagency Referral Form

DATE: _____

Client Full Name:_____ DOB:_____ Sex: _____

Phone: _____ MR#/Anasazi#: _____

Insurance:_____ Primary Language _____ Interpreter Needs: ☐ No ☐ Yes

REFERRAL FROM: *(Circle)*	**ECSS**	**NCSH**	**NCSTOO**	**NHC-D**	**NHC-E**	**NIMHC**	**NIRRC**	**TFC**	**WIAC-E**	**WIAC-V**

Referring party name: _____ Phone: _____ Fax: _____

Services being provided by referring program: ☐ Short term ☐ Ongoing (Last appt_____Next appt_____)

☐ Case Management ☐ Individual Therapy/Rehab ☐ Primary Care Medications ☐ Residential Support
☐ Group Therapy ☐ Non-medical Detox ☐ Psychiatric Medications ☐ Substance Abuse Counseling
☐ Other:

Behavioral Health Diagnosis (Check box if per client report ☐ or See Attached ☐):

Medical Diagnosis / Relevant History (Check box if per client report ☐ or See Attached ☐):

Current Medications (Check box if per client report ☐ or See Attached ☐): (dosage, frequency, current available quantity):

Other professionals involved:

Attached:

☐Authorization to Use/Disclose PHI ☐Discharge Plan ☐Progress Notes
☐Behavioral Health Assessment ☐Labs ☐Psychiatric/Medication Evaluation
☐Current Diagnosis Form /Problem List ☐Medical History Questionnaire ☐Screening Tools:
☐Demographic Form ☐Medications List ☐Other:

PURPOSE / REASON FOR REFERRAL: ☐ Routine ☐ Urgent

Reason for referral (check all that apply & write explanation): ☐ Consult ☐ Evaluation ☐ Transfer of care ☐ Treatment
Explanation:

Client's current state (i.e., symptoms, behaviors, functioning, observations/concerns, substance use w/date of last use):

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Provider name: _____ Phone: _____ Fax: _____

Appointment Date:_____ Time:_____ (☐ Check if client will make appt)

RESPONSE TO REFERRAL: ☐ Client No Show ☐ Client Cancelled Appt ☐ Client did not schedule appt

Date client seen: _____ Date client to return: _____

Disposition/Feedback/Recommendations: