Child & Adolescent Mental Health Services
1031 25th St., San Diego Ca. 92102
Phone: 619-232-6454 **Fax: 619-235-4607**

Referral cannot be processed without Student Name, SS#, DOB, and MediCal Information

Date: ____/____/____ Youth's Name: _____

Age: _____ School: _____ Grade: _____ Gender: _____

Please Circle: MediCal ◯ or No Insurance ◯ If MediCal, please indicate MediCal #: _____

DOB: _____ Social Security #: _____

Caregiver Name(s): _____ Phone Number: _____

Caregiver Address: _____

Is the caregiver or client aware of the referral to Child & Adolescent Mental Health? Please Circle: Yes ◯ No ◯

Youth's Address & Phone Number (if different from above): _____

_____

Youth's Ethnicity & Preferred Language: _____

Parent's Ethnicity & Preferred Language: _____

Referring Person's Name & Relationship to Youth: _____

Referring Agency: _____

Referring Person's Phone Number: _____ Email address: _____

Does the youth have current or prior mental health treatment? Please Circle: Yes ◯ No ◯

Current/Previous Mental Health Medication: _____

Please Check All That Apply:

- ◯ Grades Declined
- ◯ School Attendance Concerns
- ◯ Disruptive Behavior
- ◯ Hyperactive/ Inattentive
- ◯ Social Concerns
- ◯ Aggressive
- ◯ Inappropriate Sexual Behavior
- ◯ Family Concerns
- ◯ Abuse/ Neglect
- ◯ Loss/ Death/ Separation
- ◯ Alcohol/ Substance Use
- ◯ Gang Affiliation
- ◯ Homelessness/ Transient
- ◯ Legal/ Juvenile Justice/ CPS
- ◯ Anxiety
- ◯ Physical Symptoms/ Health Concerns
- ◯ Depression/ Appears Moody or Withdrawn
- ◯ Suicidal*
- ◯ Homicidal/ Terrorist Threats*
- ◯ Unusual Behaviors

(*Students experiencing suicidal/homicidal thoughts should be assessed immediately and not left unattended)

Explanation of concerns in detail: _____

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