

Name:
Type: BH Referral Form

Case#:

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Date:

**San Luis Obispo County Behavioral Health Department Behavioral
Full-Service Partnership Referral Form**

Referral Date:

Program Initiating Referral:

Program Receiving Referral:

Contact Person at Receiving Program:

Contact Person's Phone:

Referral discussed with the contact person? Yes No

Assignment made to contact person/receiving program subunit? Yes No

Reason for Referral:

Describe the reason for the referral and complete the tab fully that matches the referral you are making.

Comments/Special Considerations (Describe any additional factors the receiving program should consider, such as current potential for violence or self injury):

Signature of Staff Making Referral:

Name: Date:

Program Supervisor or Designee Approving Referral:

Name: Date:

Staff Processing Referral:

Name: Date:

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Receiving Program Comments:

- Is the referral appropriate? Yes No
- Is the referral accepted? Yes No
- Referring person notified of disposition? Yes No

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Comments by receiving program:

Signature of Staff Accepting the Referral:

Name:

Date:

San Luis Obispo County Behavioral Health Department

Full-Service Partnership

Adult FSP Yes No

- SMI, needs intensive SMHS due to hx/current functioning
- High user of MH or medical services due to MH symptoms
- Discharged from IMD within past 12 months
- Homeless or at risk of homelessness
- Current/past justice system or law enforcement involvement
- New to MH; not served in past
- Co-occurring substance use/abuse issues
- Serious vocational problems; at risk of/recently fired
- Underserved/unserved, including uninsured/indigent
- Member of a minority or disadvantaged group

Older Adult FSP Yes No

- SMI, needs intensive SMHS due to hx/current functioning
- High user of MH or medical services due to MH symptoms
- Homeless or at risk of homelessness
- Home bound and unserved
- Current/past justice system or law enforcement involvement
- New to MH; not served in past
- Co-occurring substance use/abuse issues
- Underserved/unserved, including uninsured/indigent
- Member of a minority or disadvantaged group

Forensic FSP Yes No

- SMI, needs intensive SMHS due to hx/current functioning
- High user of MH or medical services due to MH symptoms
- Discharged from IMD within past 12 months
- Homeless or at risk of homelessness
- Current/past justice system or law enforcement involvement
- New to MH; not served in past
- Co-occurring substance use/abuse issues
- Serious vocational problems; at risk of/recently fired
- Underserved/unserved, including uninsured/indigent
- Member of a minority or disadvantaged group

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Signatures

Signature

Signature Line Heading

Printed Name

Date

Staff