Name:		Case#:	Page: 1 of 4	
Type:	MH County Cooperative Program		Date:	

San Luis Obispo County Behavioral Health Department SAN LUIS OBISPO COUNTY COOPERATIVE PROGRAM Referral Form

Release of Information signed by client?	?	□ Yes □ No	
Client Name:			
Client's Phone:			
Client's Address: City/State/Zip:			
Client's DOB:	Gender:	SSN:	
Client's Conservator/Payee: Monthly Income: Source of Income: Emergency Contact Person:			
Phone: Referring Case Manager/Therapist's Phone On Probation or Parole? ☐ Yes ☐ No	one:	Contact Person: Contact Name/Agency:	
DSM Diagnosis:			
Current Medications:			
Brief Psychiatric History:			
Current Hallucinations/Delusions?	Yes [□No	
If yes, describe:			

Name: MH County Cooper	Case#: Page: 2 of 4 rative Program Date:
Current or Past Assaultive/ If yes, describe:	/Self Destructive Behaviors? □ Yes □No
Current or Past Drug/Alcoh	nol Problems? □ Yes □No
If yes, describe:	
Are there any medical cond If yes, describe:	ditions that might impact employment? □ Yes □No
Client Strengths:	
Current Living Arrangement	:
Length of time at address:	
If Board and Care, Name:	
Living Arrangement:	☐ Stable ☐ Needs to change
Rate client's potential for mo	ving to a more independent living arrangement:
□ Poor □ Fair	□ Good □ Excellent
Activities of Daily Living	
Adequate grooming?	☐ Yes ☐ No
Adequate diet?	☐ Yes ☐ No
Adequate clothing?	☐ Yes ☐ No
Able to use transportation?	☐ Yes ☐ No
Able to express needs?	☐ Yes ☐ No
Able to manage money?	☐ Yes ☐ No
Educational/Vocational Sta	atus
Able to read/write?	☐ Yes ☐ No
High School/GED?	☐ Yes ☐ No
Work History?	☐ Yes ☐ No
Vocational Rehab client?	☐ Yes ☐ No
Currently employed?	☐ Yes ☐ No
Motivated to work?	☐ Yes ☐ No

Name: Type:	MH County Cooperative Program	Case#:	Page: 3 of 4 Date:		
What are t	ne client's current support systems?				
Additional	Information/Special Considerations:				
Client Ack	nowledgement:				
l agree to	pe available and willing to participate in empl	loyment activities at	least 20 hours per week:	☐ Yes	□No
(Mu	st be yes to participate in Cooperative Progr	am)			
I agree to be free from drugs or alcohol while participating in employment services: (If not, I understand that opportunities will be limited and will be considered individually)				☐ Yes	□No
I need a medical release from my primary care or other medical doctor before I can participate in work activities for at least 15-20 hours per week:			□ Yes	□ No	
•	medical release is required, I understand that sidered individually)	at opportunities may	be limited and will be		

Name:		Case#:	Page: 4 of 4
Type:	MH County Cooperative Program		Date:

Signatures

Signature	Signature Line Heading	Printed Name	Date
	Clinician		

Program Supervisor

Health Information Technician