San Luis Obispo County Behavioral Health Department Behavioral

TMHA 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:

Receiving Program Comments:

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

Comments by receiving program:

Signature of Staff Accepting the Referral:

Name: Date:

San Luis Obispo County Behavioral Health Department

Transitions Mental Health Association Referral

Is the client currently homeless? ☐ Yes ☐No

Is client at risk of homelessness? ☐ Yes ☐ No

Does the client meet MHSA target population criteria? ☐ Yes ☐ No

Service Requested (specify):

□ Housing □ Case Management □ Supported

Employment □ Growing Grounds Farm Wellness Center (specify):

□ Life House (North County) □ Hope House (SLO) □ Safe Haven (South County)

□ Other Specify

Other Referral: ☐ Yes ☐ No

Special program

Signatures

Signature	Signature Line Heading	Printed Name	Date
	Staff		