Riverside County Mental Health Plan
PROVIDER REFERRAL REQUEST FORM

Attachment 16

Date: ______________________

Type of Plan: ☐DPSS (ACT) ☐Group Home/FFA (CARES) ☐Medi-Cal / RCHC (CARES)

Provider: ______________________ Provider #: 33 ______________________

Provider Phone #: ______________________ Provider Fax #: ______________________

Consumer Name: ______________________ Consumer DOB: ______________________

Consumer SSN: ______________________ Medi-Cal #: ______________________

Consumer Phone #: ______________________

Caretaker Name: ______________________ Caretaker Phone Number(s): ______________________

Primary Language of Consumer: ______________________ Primary Language of Caretaker: ______________________

Best Time to Reach Caretaker: ______________________

Consumer Address: ______________________

Type of Referral (***This form is to be used ***ONLY*** for additional service referrals. Use Discharge Form if you will no longer be providing any services):

☐Psychiatric Evaluation Recommended Provider: (Optional) ______________________

☐Therapy Evaluation Recommended Provider (Optional): ______________________

☐ County Clinic for all Service Due to Consumer's Severity of Symptoms (Provider to Send Discharge Form)

* Psychological Testing* use Referral for Psychological Testing Form Only

☐Other: ______________________ Recommended Provider (Optional): ______________________

Diagnosis:

Axis I: ________ ______________________

Secondary ________ ______________________

Axis II: ________ ______________________

Axis III: ________ ______________________

Axis IV: ______________________
(Specific Psychosocial Stressors)

Axis V: ________ / ________
Current Highest in Past Year

Reason for Referral(Please describe problematic behavior; be as specific as possible):

Is consumer aware of your desire to refer? ☐Yes ☐No

Is consumer (or caretaker) in agreement with referral? ☐Yes ☐No

______________________ ______________________
Provider's Signature / Title Date

____
Provider's Printed Name / Title

Send form to appropriate Authorization Unit
Community Access, Referral, Evaluation, & Support (CARES) * P O Box 7549 * Riverside, CA 92513 * Fax: (951) 358-5352
Assessment and Consultation Team (ACT) * P.O. Box 7549 * Riverside, CA 92513 * Fax; (951) 687-5819