Riverside University Health System – Behavioral Health

REFERRAL FOR SERVICES FOR FFA OR GROUP HOME CLIENT

*(To avoid delay of services, complete **ALL** form sections)*

Date: _____ Client Name: _____

Client DOB: _____ Client SSN: _____

Date of Placement: _____ Client Medi-Cal#: _____

Name of Client's Siblings:

Name of Group Home or FFA: _____

Address of FFA: _____

Client's Residence Address & Phone Number: _____

County Social Worker Name: _____ County SW Phone#: _____

Foster Parent's Name: _____

School Client is Attending: _____ Grade: _____

Desired Service: ☐ **Therapy Service** ☐ **Psychiatric Services**

Urgent Due to: ☐ **Suicidal Ideation** ☐ **Homicidal Ideation** ☐ **Out of Medication**

List Current Medications:

Rationale for Change of Provider/Requested Services (must include symptoms and how symptoms impair consumer functioning):

Developmental Delay? ☐ **Yes** ☐ **No** **Regional Center Client?** ☐ **Yes** ☐ **No**

Desired Provider (must specify): _____

Signature of Requestor: _____

Requestor's Printed Name and Title: _____

Relationship to Client: _____

Requestor's Phone Number: _____

Requestor's Fax Number: _____

Fax to Community Access, Referral, Evaluation, & Support (C.A.R.E.S.) (951) 358-5352

Confidential Patient Information. See California Welfare and Institutions Code Section 5328