UCSF Benioff Children's Hospital Oakland

MENTAL HEALTH & CHILD DEVELOPMENT REFERRAL FORM

747 52nd St., Oakland, CA 94609 • 510-428-3000 • www.childrenshospitaloakland.org

This referral will not be considered complete until all sections have been filled out.
Fax all relevant paperwork to 510-995-2956.
Package should include Behavioral Health Screening Form, IEPs, previous testing, screening forms, MCHATs, Vanderbilts, etc.

1. REFERRER CONTACT INFORMATION

Referral date____/____/____ Family informed of referral? ☐ Yes ☐ No

Referred by _____

Phone (_____)_____Fax (_____) _____

Office Name_____City _____

2. PATIENT INFORMATION

Patient's First Name_____

Last Name _____

DOB ____/____/____ MR# _____

Age_____ Gender _____

3. CAREGIVER INFORMATION

Caregiver Name _____

☐ Parent ☐ Legal Guardian ☐ Foster Family

☐ Adopted—County_____☐ Other_____

Street Address _____

City_____State_____Zip _____

Phone (_____) _____

Interpreter needed? ☐ No ☐ Yes: ☐ Parent ☐ Patient

Language_____

4. INSURANCE INFORMATION

Subscriber Name _____

DOB ____/____/____ SSN _____

Subscriber ID _____

Patient's SSN_____Medi-Cal ID_____

County _____

☐ Medi-Cal ☐ CFMG ☐ Other–Carrier _____

Insurance phone (_____) _____

If authorization is required, please obtain and fax.

5. PRIMARY CARE PROVIDER

☐ Same as referrer ☐ Children's Hospital Oakland

Provider Name _____

Clinic Name_____

Phone (_____)_____Fax (_____) _____

6. WHY REFER NOW Include recent stressors _____

_____

_____

7. MEDICAL/DEVELOPMENTAL DIAGNOSIS & HISTORY

_____

_____

8. PLEASE SELECT THE DEPARTMENT:

☐ Early Intervention Services (EIS); T: 510-428-3407
☐ Psychological Services; T: 510-428-8428
☐ Psychiatry; T: 510 428-8428
☐ Child Development Center (CDC); T: 510-428-8428
☐ McClymond's Health Center; T: 510-835-1393
☐ YU/Castlemont Health Center; T: 510-428-3556

9. CURRENT SYMPTOMS/CONCERNS

Mark all that apply.
AD=Already Diagnosed; **EN=**Evaluation Needed

AD	EN	
☐	☐	Hurting themselves / Suicidal thoughts (If in imminent threat of harm, call 911)
☐	☐	Seeing or hearing things others don't / Psychotic symptoms
☐	☐	Can't sit still / Too active
☐	☐	Difficulty following directions or paying attention
☐	☐	Anxious / Worried / Very Nervous
☐	☐	Sad / Depressed
☐	☐	Autism Spectrum
☐	☐	Not meeting milestones / Developmental delay
☐	☐	Not eating or sleeping well
☐	☐	Trouble communicating / Speech-Language delay
☐	☐	Parent/Child relationship interaction problems
☐	☐	Not making friends / Poor social skills
☐	☐	Difficulty coping
☐	☐	Behavior concerns / Tantrum / Aggression
☐	☐	Trauma / Loss / Grief
☐	☐	Significant stressors or risk factors
☐	☐	Not doing well in school / School failure
☐	☐	Difficult to soothe / Excessive crying

10. SERVICES REQUESTED

☐ Mental Health / Behavioral Evaluation
☐ Developmental Evaluation
☐ Medication Evaluation
☐ Psychological Testing
☐ Therapy–Child and/or Family
☐ Not sure

11. SERVICES CHILD HAS OR REFERRAL SENT

H=Has; RS=Referral Sent

H	RS	
☐	☐	Regional Center Services
☐	☐	Help Me Grow
☐	☐	Early Care & Education
☐	☐	Speech Therapist, OT, PT
☐	☐	SST/504/IEP
☐	☐	ERMHS (AB3632–School-Based Mental Health Services)
☐	☐	CCS
☐	☐	Therapy–Provider:
☐	☐	Psychiatrist–Provider:
☐	☐	Developmental Behavioral Pediatrician–Provider
☐	☐	Psychological Testing
☐	☐	Other: _____

UCSF Benioff Children's Hospital Oakland

DIVISION OF MENTAL HEALTH & CHILD DEVELOPMENT

RELEASE OF INFORMATION/ CONSENT FOR REFERRAL

747 52nd St., Oakland, CA 94609 • 510-428-8428 • www.childrenshospitaloakland.org

THIS RELEASE/CONSENT IS REQUIRED FOR THE REFERRAL TO BE PROCESSED.

I HEREBY AUTHORIZE THE USE AND/OR DISCLOSURE OF MY HEALTH AND MENTAL HEALTH INFORMATION TO:

UCSF Benioff Children's Hospital Oakland
Mental Health & Child Development Services
747 52nd Street
Oakland, CA 94609

PATIENT INFORMATION

Patient's Name_____Date of birth _____

Social Security #_____

PERSON/ORGANIZATION RELEASING THE PATIENT'S HEALTH AND/OR MENTAL HEALTH INFORMATION

Name/Organization _____

Street Address _____

City_____State_____Zip _____

PARENT/GUARDIAN/CAREGIVER AUTHORIZATION

Name of patient's legal representative (parent or guardian) _____

Signature _____

Phone_____Date_____

Name of patient's personal representative (if applicable) _____

Relationship to patient _____

Signature _____

Phone_____Date_____

I have the right to a copy of this authorization. Copy requested: ☐ No ☐ Yes

This authorization shall be valid for one (1) year from the date above.