

Instructions for Completing a Referral to the VCBH Provider Network

Making the referral

- STEP 1** Complete the information on the Consent Page and the Screening form.
- STEP 2** Have the guardian/adult client read and sign the consent for referral statement on the Consent Page in the appropriate language: A client cannot be referred without consent.
- STEP 3** Fax the completed Consent Page AND Screening form to the appropriate program, listed below.

What happens next?

- STEP 4** VCBH completes the Follow-Up form to triage and assign the referral to a an appropriate provider, which may be a VCBH program or contract provider.
- STEP 5** The assigned provider informs the referring party about the disposition of the referral.

If you need assistance with a referral, an update regarding the referral process, or to provide more information regarding the referral, please contact the Clinic Administrator or Officer of the Day (OD) from the appropriate program, listed below. Thank you for your patience!

<i>Dependency care youth</i>	<i>Young adults (18 to 23)</i>
Child Welfare Subsystem	VCBH Transitions Program
Fax 289-1676	Fax 981-9271
Phone 289-3383	Phone 982-9270

For all other referrals:

Oxnard Options	Ventura Options	Santa Paula Options	Conejo Options	Simi Options	Fillmore Options
Fax 981-8461	Fax 289-3395	Fax 933-0057	Fax 777-3574	Fax 582-7514	Fax 524-8655
Phone 981-8460	Phone 289-3100	Phone 525-1618	Phone 777-3505	Phone 582-7507	Phone 524-8660

CONSENT PAGE

Referral/Screening Source

Referring person: **Telephone No.:**

Referring agency: Public Health CFS Vista Del Mar Probation

School: First 5:
 VCMC Program: Other:

Date of referral: **E-Mail Address:** GroupWise

Client Information

Last name: **First name:** **MI:** **Sex:** M F

Ethnicity: Latino Caucasian African American Other

Primary Language: English Spanish Other: **Date of Birth:**

Current Residence: Shelter Care Realtive(s) Biological Parent(s) Juvenile Justice Facility
 Foster Care Residential Treatment Facility Other:

Current Services: Early Start Head Start Special Education Public Health First Five TBS
 Regional Center CFS: Worker's Name/Number:
 Probation: Officer's Name/Number: Other:

Insurance Status: Medi-Cal # Healthy Families No Insurance
 Other:

Caregiver/Contact Name: **Relationship to Youth:**

Caregiver Primary Language: English Spanish Other:

Telephone: Home **Work** **Cell**

Address: **City:** **Zip**

English Statement: I hereby give consent for Ventura County Behavioral Health (VCBH) to exchange and release information from this screening with an assigned VCBH provider or affiliated private provider in order to evaluate me / my child for mental health services. I understand that I will be contacted within 7 days by the assigned provider. If I have not been contacted within 7 days or am unsatisfied with the assigned provider, I will call (805) .

Spanish Statement: Por la presente doy consentimiento para que Ventura County Behavioral Health (VCBH) intercambie y de información de esta breve evaluación a un proveedor de VCBH asignado o proveedor privado afiliado para poder evaluar a mi / mi niño(a) para servicios de salud mental. Yo entiendo que se van a poner en contacto conmigo en menos de 7 días para asignar a un proveedor. Si no se han puesto en contacto conmigo en 7 días o menos o si no estoy satisfecho con el proveedor asignado, voy a llamar al (805) .

Parent/Guardian Signature Date

Client Signature Date

SCREENING FORM

Urgent & Emergency Questions

Quests for 18 Months old to Adult

1. Danger to self or others in the last 30 days (Reckless, talks of hurting self or others, assaulting, animal cruelty, put self in danger, self-injurious, fearless, etc.)? Yes No Unknown
2. Bizarre/unusual behavior in the last 30 days (hallucinations, smears feces, severe toileting problems, paranoid, talks to self, wanders house at night, repetitive movements/vocalizations, preoccupation with routines or objects, self-stimulating behavior, excessively accident prone, etc.)? Yes No Unknown
3. Immediate need for medication consult or refill? yes No Unknown
4. Experienced/witnessed abuse, violence, trauma, or neglect in the last 30 days? yes No Unknown
5. Behaviors placing current living, educational, or childcare situation in jeopardy (excess non-compliance, daily outbursts, frequent arrests, needs supervision, excess truancy, property destruction, impulsive/disruptive, constantly challenging caregiver, etc.)? yes No Unknown

Routine Questions

1. History of above behaviors more than 30 days ago? yes No Unknown

List:

2. Difficulty managing emotions (persistent arching, floppiness or stiffening when held; inconsolable; severe temper outbursts/tantrums; excess worry; sleeping problems or nightmares; overactive; hopeless, sad, withdrawn, or cries frequently)? yes No Unknown

Quests for 0 to 5 years old

3. Disconnected, excessively passive, or withdrawn (feeding problems; unresponsive to caregivers or environment; doesn't vocalize, cry, or smile; delayed language; doesn't play or interact with others; withdrawn; loss of previous skills, etc.)? yes No Unknown

Quests for 18 months old to Adult

4. Social adjustment problems (damages property of self or others, runs away, lack of guilt or concern for others, steals, fights, mute, etc.)? yes No Unknown

Quests for 6 years old to Adult

5. Problems making and maintaining healthy relationships (poor peer relationships, poor bond with caregiver, gang involved, provokes & victimizes)? yes No Unknown
6. Personal care problems (poor hygiene, wets/soils self, eats non-food items, etc.)? yes No Unknown
7. Significant functional or daily living problems (significant language delays, can't manage age appropriate skills, difficulty sleeping, difficulty understanding others, etc.)? yes No Unknown
8. Known to abuse alcohol and/or drugs? yes No Unknown

Medical issues:

Reason for referral/comments:

VCBH FOLLOW-UP (Completed by VCBH ONLY)

Clinician conducting follow-up: _____ Date of follow-up: _____

What types of services is the caller interested in?

- Psychiatric Therapy Group Drug/Alcohol Education/Speech & Language
 Housing Health/Medical Parent Ed./Skills Vocation/Employment
 Other

Additional info:

Statement of Consent

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_____ _____ _____ _____
 Parent/Guardian Signature Date Client Signature Date

_____ _____ Phone consent obtained from Client Parent/Guardian
 Staff Signature Date

Ventura County Behavioral Health Confidential Patient Information Welfare & Institutions Code 5328 and Evidence Code 1014	Youth & Family Interagency Screening Follow-Up	Name: _____ ID#: _____ Site #: _____
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Case Disposition (completed by clinician)

Status Routine No case made (why: _____)
 Urgent: **Must offer** the client/family an appointment that occurs within the next 24 hours
 Emergency: Immediate intervention

Referrals Centralized Screening Other _____

Interventions Contact Police Contact CIRT Parent informed about CIRT CFS report - date _____
 Other: _____

Triage (completed by centralized screening team)

Refer out Provider Network: _____ Access Line
 NFL: _____ Client's private insurance
 Other: _____

Refer in (VCBH) Clinic/Prog: _____ Psychiatrist: _____
 Clinician: _____ Other: _____

Other referrals CMC Med Clinic Healthcare for Kids Pub. Health Regional center
 United Parents Other: _____

Outreach Information (completed by VCBH/contractor staff as referral is processed)

Date of first contact with clinic: _____
 Date screen completed: _____
 Clinician appt: Date 1st available _____ Physician appt: Date 1st available _____
 Clinician appt: Date 1st made _____ Physician appt: Date 1st made _____
 Clinician appt: Date 1st seen _____ Physician appt: Date 1st seen _____
 If VCMC referral, date results sent to physician _____

Outreach attempts: _____

Final disposition: _____

Comments: _____

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