NEXT MOVE
Supporting Justice-Involved Youth

COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

All referrals can be either faxed to (619) 399-3724 or securely emailed to: NextMoveProgram.BHS@sdcounty.ca.gov

Referral Information

Name of Referring Party:	**Date of Referral:**
Email Address:	**Phone Number:**

Referred By: ☐ Probation ☐ CHP ☐ CFWB ☐ PD/AD Office ☐ Court ☐ Self ☐ Other

Projected Release Date (if applicable): _____ Next Court Hearing Date (if applicable): _____

Upcoming Re-Entry MDT Date (if applicable): _____

Contacts: Assigned Probation Officer (Name/Phone #): _____

Public Defender (Name/Phone #): _____

CFWB Social Worker (Name/Phone #): _____

Status: ☐ Formal Probation ☐ Informal Probation ☐ CFWB ☐ None

Requested Service Type: (youth will be screened for all services)

☐ Individual/Family Therapy ☐ Functional Family Therapy (FFT) ☐ Psychiatry ☐ Anger Mgmt. Group
☐ DBT Group ☐ Substance Use Group ☐ CSEC Group ☐ Requested Clinician (if appl.): _____

Safety and Risk Information: (check all that apply)

☐ History of assaultive or aggressive behavior toward staff
☐ Gender-specific safety concerns (e.g. concerns for female staff)
☐ Suicidal Ideation or Behaviors
☐ Homicidal Ideation or Behaviors
☐ Substance Use
☐ History of Psychiatric Hospitalization
☐ Gang Involvement/Affiliation
☐ Sex Trafficking or Exploitation Concerns
☐ No Contact/Restraining Orders
☐ Other: _____

Service Setting Recommendation:

☐ Community-based (field) services are appropriate
☐ Office-based services are recommended due to safety or other concerns

Youth Information

Name of Youth:	**Phone Number:**
Date of Birth:	**Age:**
Gender Identification:	**Ethnicity:**
Youth Preferred Language:	**Caregiver Preferred Language:**
Caregiver Name:	**Caregiver Phone Number:**
Address with ZIP Code:	

Youth Insurance Status: ☐ Medi-Cal—Number: _____ ☐ Uninsured

Current Mental Health Diagnosis:

Is youth currently followed by psychiatry?: ☐ NO ☐ YES Name/Phone #: _____

Current Medications: _____

→ Date last dose taken: _____ → Date refill needed by: _____

Documents Included

(Please check all documents included with the referral packet)

☐ Social Study ☐ Psychological Eval (if avail.) ☐ Mental Health Records from CHP ☐ Other Relevant Reports

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EMAIL FORM TO NEXT MOVE

OFFICE USE ONLY

☐ **URGENT**		☐ **NON-URGENT**
BH Links Referral: ☐ NO ☐ YES	Clinical Documentation attached: ☐ YES ☐ NO	
Date Referral Received:	**Assigned Clinician:**	**Date Screening Completed:**
Eligible for Next Move: ☐ No	☐ Yes as BH Links	☐ Yes as Community
First Appointment Offered:	**First Appointment Scheduled:**	**Informed Referring Party of Status:**
Notes:		