County of San Diego HHSA Adult/Older Adult Behavioral Health Services
STRENGTHS-BASED CASE MANAGEMENT (SBCM)
REFERRAL FORM

** Hover the pointer over the program title, right click the mouse and select "Open Hyperlink" for more information. ***

REFERRAL TO STRENGTH-BASED CASE MANAGEMENT (SBCM) PROGRAMS

☐ Community Research Foundation Maria Sardiñas Wellness Recovery Center (South):
(619) 428-1000; mailto:MSCCMReferrals@comresearch.org

☐ Community Research Foundation South Bay Guidance Wellness Recovery Center (South):
(619) 427-4661; mailto:SBGCCMReferrals@comresearch.org

☐ County of San Diego SBCM - Central/North Central:
(619) 692-8715; mailto:CCMreferrals@sdcounty.ca.gov

☐ County of San Diego SBCM - East:
(619) 401-5424; mailto:CCMreferrals@sdcounty.ca.gov

☐ TURN Behavioral Health Services SBCM TAY North:
(760) 888-2175; mailto:SBCMNorth.referrals@turnbhs.org

☐ TURN Behavioral Health Services SBCM North:
(760) 888-2175; mailto:SBCMNorth.referrals@turnbhs.org

☐ Telecare AgeWise Older Adult SBCM (Countywide):
(619) 481-5200; mailto:agewise@telecarecorp.com

REFERRING PARTY INFORMATION

Date of Referral: Name of Person Making Referral:

Email of Referring Party, if available*:

Referring Agency: Address:

Phone: Fax:

*If choosing to communicate via email, please ensure compliance to Article 14 and confidentiality requirements. Email may be used between providers and referring parties as long as no client information is included unless encryption is used. This referral form should never be sent via email unless encrypted.

IDENTIFYING INFORMATION OF PERSON BEING REFERRED

Name: SS# (Last 4 ONLY): DOB: Age: MIS#:

Aliases: Gender: Language of Preference: Ethnicity:

Address: Phone:

Has he/she ever been Homeless? ◯YES ◯NO Period of Homelessness:

Is he/she connected to Whole Person Wellness? ◯YES ◯NO

Alternate Telephone Number or Other Supports: Relation: Phone:

CLINICAL INFORMATION

Is Person Interested in Case Management? ☐ YES ☐ NO Provide Specific Reason(s) for Referral:

Current Problems, Barriers, Challenges, OR Problems When Person is Not Stable:

Mental Health Stage of Recovery: ☐ Pre-Contemplation ☐ Contemplation ☐ Preparation ☐ Action ☐ Maintenance ☐ Relapse

History of Mental Health Treatment:

Number of Psych Hospitalizations in the past year: Reasons:

Does Person Have Problematic Use of Substances? ☐ YES ☐ NO Date of Last Use:

Substance(s) of Choice:

Substance Use Stage of Recovery: ☐ Pre-Contemplation ☐ Contemplation ☐ Preparation ☐ Action ☐ Maintenance ☐ Relapse

History of Drug/Alcohol or Co-Occurring Treatment:

Risk for Harm or Dangerous Propensities (e.g., Suicide Attempts, SI, HI, Command AH, Hx of Violence, Threats, Risky Behavior):

Current Impairments in Daily Functioning:

Goals, Strengths, and Interests:

CULTURAL FACTORS RELATED TO MENTAL HEALTH:

DIAGNOSES

Primary:

Secondary:

Other(s):

Medical condition(s) important to the understanding or management of an individual's mental disorder(s):

Psychosocial and contextual factors (use V&Z codes most relevant to the mental disorder):

CURRENT MEDICATIONS:

Current Treating Psychiatrist: Phone:

CURRENT MEDICAL ISSUES:

Primary Care Physician: Phone:

LEGAL INFORMATION

Is Person Conserved? ☐YES ☐NO Name of Conservator: Phone:

Has Person been Incarcerated or Had Legal Issues? ☐ YES ☐ NO If yes, please explain:

Person is on ☐Parole ☐ Probation Parole/Probation Officer: Phone:

Other Pertinent Legal Information or Restrictions:

FINANCIAL / INSURANCE INFORMATION

Current Source of Income: ☐ SSI ☐ SSDI ☐ SDI ☐ WORK ☐ NONE ☐ Other:

Payee: Phone:

Current Insurance Status: ☐ Medi-Cal ☐ Medicare ☐ VA ☐ Indigent

Medi-Cal #: Medicare #:

Private/Other Insurance Information: Policy #: Phone:

Signature of Person Completing Referral: Date:

This electronic form can also be found in the Technical Resource Library (TRL).