



REFERRAL TO INSTITUTIONAL CASE MANAGEMENT (ICM) PROGRAMS

*Client must be under LPS Permanent Conservatorship/PCON status for this referral form.
Please attach Conservator's Investigation Report & Letters and Orders to the referral email.

REFERRAL TO INSTITUTIONAL CASE MANAGEMENT (ICM) PROGRAMS

- [County of San Diego ICM \(18-59 years old\):](#) (619) 692-8715; <mailto:CCMreferrals@sdcounty.ca.gov>
- [Telecare AgeWise ICM \(60 and over\):](#) (619) 481-3850; <mailto:agewise@telecarecorp.com>

REFERRING PARTY INFORMATION

Date of Referral: _____ Name of Person Making Referral: _____

Email of Referring Party, if available*: _____

Referring Agency: _____ Phone: _____

*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: _____ EHR#: _____

Aliases: _____ Gender: _____ Language of Preference: _____ Ethnicity: _____

Facility Address: _____ Facility Phone: _____

Date of Placement: _____ Estimated Facility Length of Stay: _____

DIAGNOSES

Primary: _____

Secondary: _____

Other(s): _____

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

Clinical Presentation including Psychosocial and social determinants of health: _____

CLINICAL INFORMATION

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

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

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

Current Treating Psychiatrist:

Phone:

CULTURAL FACTORS RELATED TO MENTAL HEALTH:

CURRENT MEDICATIONS:

Current Treating Psychiatrist:

Phone:

CURRENT MEDICAL ISSUES:

Primary Care Physician:

Phone:

LEGAL INFORMATION

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:

Update Demographic Form prior to submission

Person Completing Referral:

Date: