

County of San Diego HHS 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>

 - [Mental Health Systems \(MHS\) SBCM North:](#)
(760) 294-1281; <mailto:SBCMNorth.referrals@mhsinc.org>
- Adult Referral TAY Referral
- [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 \(TRL\)](#).