# CARE REFERRAL

PATIENT REFERRAL INFORMATION TO BE COMPLETED BY A LICENSED BEHAVIORAL HEALTH PROFESSIONAL EMPLOYEE OR CONTRACTED BY A FACILITY WHO HAS KNOWLEDGE OF THE INDIVIDUAL'S CASE AND HAS BEEN INVOLVED IN THEIR TREATMENT DURING THE HOLD OR THEIR DESIGNEE.

The referring person will complete and submit the referral form via email to BHSCAREteam.HHSA@sdcounty.ca.gov

Required documentation: (please attach to email)
☐ Release of information (ROI)
☐ Facility demographic form
☐ Facility psychiatric assessment
☐ Any relevant documentation

Hold dates:
☐ 1st day of 72-hour hold _____
☐ 1st day of 14-day hold _____
☐ 1st day of 30-day hold _____
Anticipated discharge date: _____
End date of involuntary hold: _____

LICENSED BEHAVIORAL HEALTH PROFESSIONAL INFORMATION:

Provider Name: _____ Today's Date: _____
Provider Email: _____ Provider Phone: _____
Facility Name: _____ Facility Fax: _____
Facility Address: _____

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Name: _____
Address: _____ City: _____ Zip Code: _____

If address is unknown, please provide the last known location and any additional information to locate the individual:
_____
_____
Phone: _____
Medi-Cal Client Index Number: _____ Social Security Number (if available): _____
Emergency Contact: _____ Emergency Contact Phone: _____

1. Patient *(check all that apply):*

   ☐ Is a resident of San Diego County
   ☐ Is currently located in San Diego County

# CARE REFERRAL

☐ Is a defendant or respondent in a criminal or civil proceeding pending in the superior court of San Diego County
☐ Is a resident of (specific county if known and different from San Diego County): _____

Patient meets each of the following requirements and is eligible to participate in the CARE Act process and receive services and support under a CARE agreement or CARE plan *(provide information below to support each requirement):*

2. ☐ Patient is 18 years of age or older. Date of birth: _____

3. DSM Code and Diagnosis:

| DSM Code: | Diagnosis: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

4. Patient is currently experiencing a serious mental disorder, as defined in Welfare and Institutions Code section 5600.3(b)(2), in that the disorder *(check all that apply):*

   ☐ Is severe in degree and persistent in duration
   ☐ May cause behavior that influences substantially with patient's primary activities of daily living
   ☐ May result in patient's inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period.

5. Patient is not currently stabilized in ongoing treatment. Patient's current stability and treatment are described:

6. At least one of these is true: *(check all that apply):*

   ☐ Patient is unlikely to survive safely in the community without supervision and patient's condition is substantially deteriorating. Reasons that patient is unlikely to survive safely in the community, the type of supervision patient would need to survive safely, and the extent to which the patient's physical or mental condition has recently grown worse are described:

# CARE REFERRAL

☐ Patient needs services and supports to prevent a relapse or deterioration that would be likely to lead to grave disability or serious harm to patient or others. The services or supports needed by patient and the reasons patient would become gravely disabled or present a risk of harm to self or others are described:

7. Patient is likely to benefit from participation in a CARE Agreement. Reasons in support of this assertion are provided:

_____

8. Check any of the following statements that are true and give the requested information:
   a. ☐ Patient needs interpreter services or an accommodation for a disability *(if known, describe patient's needs):*

      _____

   b. ☐ Patient is served by a regional center *(if known, give the center name and the services provided to patient):*

      _____

   c. ☐ Patient is a current or former member of the state or federal armed services or reserves *(branch name, if applicable:*

      _____

9. If applicable:

   ☐ Patient was detained for at least two periods of intensive treatment, the most recent period within the past 60 days. ***Note:*** *For purposes of the CARE Act, "intensive treatment" refers to involuntary treatment authorized by Welfare and Institutions Code section 5250. It does* ***not*** *refer to treatment authorized by any other statutes including but not limited to Welfare and Institutions sections 5150, 5260, and 5270.15.* Please explain:

# CARE REFERRAL

## Documentation of Authority to Make a Referral

By signing below, I confirm that I am a licensed behavioral health professional employed or contracted by the facility, who has knowledge of the individual's case, has been involved in the individual's treatment during their involuntary hold, and believes that the individual meets or is likely to meet criteria to qualify for the CARE process in California Welfare and Institutions Code section 5972, or I have been designated to sign on behalf of the individual.

| | |
|---|---|
| Printed name of licensed behavioral health professional | Signature of licensed behavioral health professional |
| License type and number | Date |

OR

| | |
|---|---|
| Printed name of designee | Signature |
| License type and number (write "N/A" if not applicable) | Date |