NEXT MOVE
Supporting Justice-Involved Youth

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

Referring Party Information

Name:	**Date of Referral:**
Email Address:	**Phone Number:**
Referred By: ☐ Probation ☐ Court ☐ PD/AD Office ☐ CHP ☐ Self ☐ Other:	
Projected Release from: ☐ YTC on: ☐ EM on:	
Probation Status: ☐ Formal Probation ☐ Informal Probation ☐ Dual Youth ☐ Community Supervision ☐ None	
Additional Information:	

Youth Information

Name:	**Phone Number:**
Date of Birth:	**Age:**
Gender Identification:	**Ethnicity:**
Language Preference:	**Current Treatment Provider:**
Address with ZIP Code:	
Please select the location(s) where youth would prefer to receive services: ☐ North Coastal Live Well Health Center: 1701 Mission Avenue, Ste. 110, Oceanside, CA 92058 ☐ Southeastern Live Well Health Center: 5101 Market Street, Ste. 2100, San Diego, CA 92114 ☐ Telehealth/Remote Video Sessions ☐ Near the following ZIP Code:	
Current Mental Health Diagnosis:	
Please state if youth has any specific physical, cultural, or gender orientation needs:	
Current Medications:	
Known Gang Affiliation? ☐ YES ☐ NO — If yes, which gang?: ☐ Unknown:	
Child Active to San Diego Regional Center? ☐ YES ☐ NO ☐ Unknown:	

Youth Information *(cont.)*

Describe youth living arrangement post release *(check all that apply)*:

- ☐Parent/Caregiver
- ☐In a Shelter
- ☐Vehicle
- ☐Hotel
- ☐Public Space (Transient)
- ☐Group Home/THP
- ☐Couch Surfing
- ☐Other:

Additional Information:

Placement history outside of parent/caregiver's home *(check all that apply if known)*:

- ☐RFA Home (Relative/NREFM/LFH)
- ☐Foster Family Agency/Foster Home
- ☐YTC/EM
- ☐Temporary Shelter Care Facility (ex. PCC)
- ☐Group Home/STRTP
- ☐Residential Substance Use Treatment Program
- ☐Other:

Additional Information:

Youth Insurance Status:

- ☐Medi-Cal—Number:
- ☐Uninsured
- ☐Private Insurance—Name:
  Policy Number:

Reason(s) for referral *(please be detailed and include mental health, behavioral concerns, substance use concerns, high risk behaviors, impairment in functioning, criminogenic needs, etc.)*:

Youth/Caregiver Risk Factor(s) and Safety Concern(s) *(check all that apply)*:

- ☐Suicidal Ideation/Behaviors
- ☐Homicidal Ideation/Behaviors
- ☐Substance Use
- ☐Physical Aggression
- ☐Domestic Violence
- ☐History of Hospitalization
- ☐No Contact/Restraining Orders
- ☐Sex Trafficking
- ☐Running Away
- ☐Other:

Additional Information:

Overall Safety Considerations:

Caregiver Information	
Name:	**Relationship to Youth:**
Phone Number/Alternate: /	**Language Preference:**
Has Caregiver been informed of referral? ☐ YES ☐ NO ☐ Not Applicable—Youth Over 18	
Has Caregiver agreed to services? ☐ YES ☐ NO ☐ Not Applicable—Youth Over 18	
Address with ZIP Code:	
List any non-custodial parent/caregiver and their contact information:	

Release of Information attached: ☐ YES ☐ NO

Verbal Consent of Caregiver Received on:

Verbal Consent of Youth Received on:

OFFICE USE ONLY		
Referral Received:	**Assigned Clinician:**	**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:		

EMAIL FORM TO NEXT MOVE