El Centro Del Pueblo
Outpatient Mental Health Program
1157 Lemoyne St. Los Angeles CA 90026
Tel: 213.483.6335 | **Fax:** 213.483.9876(please fax, do not email)

Provider/Agency Referral for Mental Health Services

Date of referral: _____

Client Information

Name _____ Date of Birth _____

Language _____ Age _____

Gender _____ Ethnicity _____

School _____ Grade _____

Address _____

City _____ ZIP _____

Phone (home) _____ Phone (cell) _____

Client must have full-scope Medi-Cal insurance.

Please Provide Medi-Cal # _____ Issue Date: _____

Parent/ Caregiver Information (If client is a minor)

Name _____ Language _____

Address _____

City _____ ZIP _____

Phone _____ Phone (other) _____

Best time to call _____

I acknowledge that my child is being referred to El Centro Del Pueblo for Mental Health services. I understand that someone from El Centro Del Pueblo will be contacting me about this.

Yo comprendo que mi hijo(a) ha sido referido para los servicios de salud mental en El Centro Del Pueblo. Yo entiendo que alguien me llamará sobre este asunto.

Parent Signature: _____

Referral Source

Agency Name _____

Address _____

Agency Contact Person _____ Phone _____

Reason for Referral

Why is the client seeking services at this time(Please be specific/describe problematic behaviors & symptom(s)?

Any additional information that you feel is relevant: