EL CENTRO DEL PUEBLO MENTAL HEALTH PROGRAM
1157 Lemoyne St, Los Angeles, CA 90026
Tel (213) 483-6335 Fax (213) 483-9876

Mental Health Referral Form

Date:	
Referring Party Name:	**Relation to Child:**
Referring Party Phone Number:	☐ Obtained Parent/Caregiver Consent for Provider Contact
MEDI-CAL INFORMATION	
Medi-Cal Number:	Issue Date:
CLIENT INFORMATION Client Name: Date of Birth: Age: SSN#: Gender: ☐ M ☐ F Ethnicity: Grade: IEP: ☐ YES ☐ NO SST: ☐ YES ☐ NO DCFS involvement: ☐ YES ☐ NO Probation involvement: ☐ YES ☐ NO Gang involvement: ☐ YES ☐ NO	**CAREGIVER INFORMATION** Caregiver Name(s): Language: ☐ English ☐ Spanish Home Phone: Cell Phone: Home Address: Best time to reach family:

FUNCTIONING AT SCHOOL/HOME (Check all that apply):

☐ Gets Angry Easily ☐ Worries ☐ Appears Sad/Cries ☐ Gets teased/bullied
☐ Disruptive at home/class ☐ Easily Distracted ☐ Nightmares ☐ Sees/hears things that aren't there
☐ Physically aggressive (hitting/kicking/punching) ☐ Verbally aggressive (threatening, name calling)
☐ Suicidal thoughts ☐ Homicidal thoughts

Previous Mental Health Treatment:

☐ No ☐ Yes	Where:	Approximate Dates:

Psychiatric Hospitalization:

☐ No ☐ Yes	Where:	Approximate Dates:

Current Medication, if any:

History of Violence: ☐ Yes ☐ No **History of Substance Use:** ☐ Yes ☐ No **Firearms in the home:** ☐ Yes ☐ No

Trauma History or Stressors:

Additional Comments: