



Child & Adolescent Mental Health Services

1031 25th St., San Diego Ca. 92102

Phone: 619-232-6454

Fax: 619-235-4607

Referral cannot be processed without Student Name, SS#, DOB, and MediCal Information

Date: ___/___/___ Youth's Name: _____

Age: _____ School: _____ Grade: _____

Please Circle: MediCal or No Insurance If MediCal, please indicate MediCal #: _____

DOB: _____ Social Security #: _____

Caregiver Name(s): _____ Phone Number: _____

Caregiver Address: _____

Is the caregiver or client aware of the referral to Child & Adolescent Mental Health? Please Circle: Yes No

Youth's Address & Phone Number (if different from above): _____

Youth's Ethnicity & Preferred Language: _____

Parent's Ethnicity & Preferred Language: _____

Referring Person's Name & Relationship to Youth: _____

Referring Agency: _____

Referring Person's Phone Number: _____ Email address: _____

Does the youth have current or prior mental health treatment? Please Circle: Yes No

Current/Previous Mental Health Medication: _____

Please Check All That Apply:

- | | | |
|-------------------------------|------------------------------|--|
| Grades Declined | Family Concerns | Physical Symptoms/ Health Concerns |
| School Attendance Concerns | Abuse/ Neglect | Depression/ Appears Moody or Withdrawn |
| Disruptive Behavior | Loss/ Death/ Separation | Suicidal* |
| Hyperactive/ Inattentive | Alcohol/ Substance Use | Homicidal/ Terrorist Threats* |
| Social Concerns | Gang Affiliation | Unusual Behaviors |
| Aggressive Behavior | Homelessness/ Transient | |
| Inappropriate Sexual Behavior | Legal/ Juvenile Justice/ CPS | |
| | Anxiety | |

(*Students experiencing suicidal/homicidal thoughts should be assessed immediately and not left unattended)

Explanation of concerns in detail: _____

