

**POSITIVE SOLUTIONS**  
A program of Union of Pan Asian Communities  
**REFERRAL FORM**



**Please email this form to [yesquivel@upacsd.com](mailto:yesquivel@upacsd.com) Attn: Program Manager or,**  
**Call us at 619-481-2652 with the following information to make the referral.**  
**Services are provided via telehealth.**

Today's date:

\* Required Fields.

**IS THE INDIVIDUAL:**

- \*At least 60 years old?    YES    NO  
\*Homebound or socially isolated?    YES    NO  
\*Depressed, overwhelmed or at risk?    YES    NO  
\*Having suicidal thoughts, homicidal thoughts or in crisis?    YES    NO  
\*Showing signs of dementia or any other type of cognitive impairments?    YES    NO

If yes, please describe what is observed:

Having a psychotic episode? (Hallucinations, bizarre thoughts, etc.)    YES    NO

\*Currently receiving mental health services?    YES    NO

If yes, please provide name and type of service provider:

**CONTACT INFORMATION FOR OLDER ADULT:**

\*Last Name:                      \*Name:                      \*Address:                      \*City:                      \*Zip Code:  
\*Phone Number:                      \*Language(s):                      \*Monolingual?    YES    NO  
\*Gender:                      \*DOB:                      Age:                      Preferred Call Times:  
Trusted Emergency Contact (if applicable):                      Relation:                      \*Phone #:

**REFERRING PARTY INFORMATION**

Self-Referral/Referring Party:                      Phone Number:

**CLINICAL INFORMATION**

\*Individual's report of problems/goals:  
Psychotropic medications?  
Case management issues:  
Safety issues (pets, odors, environment):  
Significant life events and physical limitations (specific dates):  
  
History of Addiction/Substance Use?    UNKNOWN    NO    YES    If Yes, approximate date of last use:  
Substance(s) of Choice:  
History of Treatment(s) for Drug/Alcohol or Co-Occurring issues:  
Risk factors: (gambling, suicide attempts, SI, HI, command AH, property damage, threats, risky behaviors):

Person Completing Referral:                      Title:                      Date:

**PSP Office Use Only**  
**Client #**

For Internal Use Only