Crisis Residential Program [CRP]

SACRAMENTO COUNTY

REFERRAL FORM

Date of Referral:

Client Name: **Client ID #:**

DOB:

Please describe the current symptoms and behaviors that necessitate referral for Crisis Residential Services:

Based on your assessment and knowledge of the client's current symptoms and situation, what are the current mental health treatment needs? (Treatment needs must meet medical necessity; although environmental factors contribute to crises, housing and substance abuse issues alone do not meet medical necessity.)

What is the estimated length of stay needed to stabilize symptoms? ◯ Up to 14 days ◯ 15-30 days

Current Mental Health Diagnosis per DSM V

Primary Diagnosis:
Diagnosis 2:
Diagnosis 3:
Diagnosis 4:
Diagnosis 5:

Source of Diagnosis:
Date of Diagnosis:

Conservatorship?

☐ Yes,
Contact Info:

☐ No

Source of Income

☐ SSI
☐ SSDI
☐ GA
☐ None
☐ Other:

Name of support person(s) in the community

1.
2.

Current Medication(s) (psychiatric & medical)

1.
2.
3.
4.
5.

Please describe any history of assaultive/aggressive/violent/ threatening behavior and date of last occurrence:

Name of Client's Primary Care Physician

Client Living Situation

Where does the client sleep at night? Is their living situation temporary even though it's more than one night? Where did they sleep before being hospitalized?

☐ Board and Care
Homeless
- ☐ Respite (Abiding Hope, TLCS, etc.)
- ☐ Temporary Shelter
- ☐ With Family/Friend (Couch Surfing)
- ☐ Emergency Shelter
- ☐ Uninhabitable Space (i.e. under bridge)
- ☐ Hotel/Motel

☐ House/apartment
☐ Room and Board
☐ Supported housing
☐ Unknown
☐ Other:

Co-occurring Substance Use: ☐ Yes ☐ No

Please describe any substance use or abuse challenges and date of last occurrence:

Please describe any cultural/language/spiritual accommodations or needs:

I have discussed this referral with the client and client agrees with referral: _____ ***Please INITIAL***

Referral Source Staff Name:	Referring Hospital/Program Name:	Referral Source Phone Number:

Please fax this completed referral form, along with records, and LIC 602 form to: Referral Fax Line: (916) 244-2751; Capital Star Phone Line: (916) 890-3000