

Intensive Outpatient Services – Riverside County Screening and Referral Form

Individual's Name: _____ Date of Referral: _____

Address: _____

Caregiver Name: _____ Placement type: _____

Telephone # _____ Medi-Cal #: _____ Issue Date: _____

ELMER#: _____ Social Security #: _____ DOB: _____ Gender: _____

Race/Ethnicity: _____ Primary Language: _____ Marital Status: _____

Grade in School: _____ Allergies: _____

Family Military Involvement- Branch: _____ Native American Tribe: _____

Referral Agency: _____

Referral Agency Contact: _____ Supervisor: _____

Desk: _____ Cell: _____ Email: _____

Reasons for referral (primary Presenting Problem) _____

Current ICD-10 Diagnosis (if known): _____

Medical condition or illness (if known or relevant) _____

Current Medications and Dosage: _____

Family History (check if yes):

Referral is precipitated by a recent event or crisis: _____

History of previous services _____

History of trauma, Provide very brief description: _____

General description of childhood, including any significant positive or traumatic events: _____

Current drug and alcohol use/abuse of family members
If yes, list family member and drug/alcohol being used and/or abused: _____

School (check if yes):

- Individual in School/Name of School and Address: _____
- Academic performance needs, learning disabilities, placement in special classes _____
- History of repeating grades _____
- History of behavioral problems at school _____
- Involvement in extracurricular activities (sports, hobbies) _____

Risk Factors

- Suicidal Ideation
- Recent Psychiatric Hospitalization
- Child Abuse/Neglect
- Homicidal Ideation
- Hallucinations/Delusions
- Self Harm (i.e. cutting, burning)
- Community Violence
- Odd Thinking/Behavior
- Other Trauma, please specify:
- Sexual Abuse
- Drug or Alcohol Use

Home Environment

- Recent Immigrant
- Family Violence
- Death/Loss
- Divorce/Separation
- Military-Connected Family
- Foster Home/Lives with Relative

School Performance

- Failing Grades
- Does Not Complete Assignments
- Speech/Language Concerns
- Performing Below Grade Level/Ability
- Known/Suspected Learning Disability
- Newcomer/School Adjustment Problems

Birth to Age 5

- Difficulty Separating
- Poor Emotional Regulation
- Problems with Sleep
- Problems Relating to Peers
- Delayed Language Development
- Wets/Soils Self
- Health Problems
- Temper Tantrums

Behavior/Social and Emotional Functioning

- Sadness/Depression
- Anxious/Nervous
- Withdrawn/Shy
- Disruptive/Defiant Behaviors
- Recent Weight Gain/Loss
- Impulsive/Hyperactive
- Aggressive/Tantrums
- Does Not Take Responsibility
- Truancy
- Poor Hygiene
- Sexualized Behavior
- Poor Social Skills

Comments:

For Office Use Only:

Assigned to: _____ Assigned by: _____

Date assigned: _____ Date contacted: _____ Start Date: _____

Notes: _____
