



Referral Form | CHAT

Glenn County Health and Human Services – Behavioral Health Department

Referral Date: _____

YOUTH CONTACT INFORMATION	
Youth Last Name:	Youth First Name
Street Address:	City/State: Zip:
Home Number:	Youth's Cell Phone Number:
Is youth currently 12 or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is youth consenting to their own services? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If YES, can parents be contacted about treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, please provide phone number and address where youth can be contacted.	
Phone Number:	Mailing Address:
YOUTH DEMOGRAPHIC INFORMATION	
Birthdate:	Current Age: Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Ethnicity	Is the youth of Hispanic or Latino origin? <input type="checkbox"/> Yes, Hispanic or Latino Origin (if known, check all that apply) <input type="checkbox"/> Not of Hispanic or Latino Origin <input type="checkbox"/> Unknown <input type="checkbox"/> Mexican-American/Chicano <input type="checkbox"/> Latin American <input type="checkbox"/> Spanish
Race (Check all that apply)	<input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Other (specify) _____
Youth's Primary Language (choose one)	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Lao <input type="checkbox"/> Hmong <input type="checkbox"/> Other (specify) _____
Disability (Check all that apply)	<input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Speech <input type="checkbox"/> Learning <input type="checkbox"/> Physical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other (specify) _____
FUNDING SOURCE	
Social Security Number: _____ - _____ - _____	
<input type="checkbox"/> No Insurance <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medi-Cal: <input type="checkbox"/> Other (specify) _____	
SCHOOL	
What school is youth attending? _____ What grade is the youth in? _____	
Failing One or More Classes <input type="checkbox"/> Yes <input type="checkbox"/> No IEP (Individual Education Plan) <input type="checkbox"/> Yes <input type="checkbox"/> No Expelled <input type="checkbox"/> Yes <input type="checkbox"/> No	
Learning Disability <input type="checkbox"/> Yes <input type="checkbox"/> 504 Plan <input type="checkbox"/> Yes <input type="checkbox"/> No Suspended <input type="checkbox"/> Yes <input type="checkbox"/> No	
CURRENT LIVING SITUATION	
Is child currently homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No Is child currently living in a shelter? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is child currently involved with Child Welfare? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, <input type="checkbox"/> Voluntary <input type="checkbox"/> Family Reunification <input type="checkbox"/> Family Maintenance <input type="checkbox"/> Adoptions/Permanente Placement <input type="checkbox"/> Other (specify) _____	
If yes, <input type="checkbox"/> Living independently <input type="checkbox"/> Living with parent(s) <input type="checkbox"/> Living with relative(s) <input type="checkbox"/> Living with non-relative(s)	
<input type="checkbox"/> Foster Family Home <input type="checkbox"/> Group Home Level <input type="checkbox"/> Other (specify) _____	
If yes, social worker name: _____ Contact Information: _____	
CAREGIVER CONTACT INFORMATION	
Birth Mother's Name:	Phone Number: _____
Birth Father's Name:	Phone Number: _____
For children placed out of home, who has legal rights? <input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Caregiver listed <input type="checkbox"/> Social Worker <input type="checkbox"/> Other (specify) _____	
Caregiver's Last Name:	Caregiver's First Name:
Relationship to Youth:	Caregiver's Phone <input type="checkbox"/> Same as Child
Primary Language of Caregiver (choose only one): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Lao <input type="checkbox"/> Hmong <input type="checkbox"/> Other (specify) _____	
REFERRAL INFORMATION	
Referring Person:	Referral Phone: () - -
Referral Agency/Unit	<input type="checkbox"/> SMART <input type="checkbox"/> Child Welfare <input type="checkbox"/> Victim Witness <input type="checkbox"/> School: _____ <input type="checkbox"/> Other (specify) _____
Types of Victimization (Check all that apply)	
<input type="checkbox"/> Domestic Violence/Family Violence <input type="checkbox"/> Child physical abuse & neglect <input type="checkbox"/> Bullying <input type="checkbox"/> Hate Crime <input type="checkbox"/> Teen Dating <input type="checkbox"/> Victim of Fire <input type="checkbox"/> Burglary	
<input type="checkbox"/> Child Pornography <input type="checkbox"/> Child Sexual Assault/Abuse <input type="checkbox"/> Victim of DUI/DWI <input type="checkbox"/> Human Trafficking (Labor or Sex) <input type="checkbox"/> Identity theft/financial fraud	
<input type="checkbox"/> Kidnapping (Custody or Non Custody) <input type="checkbox"/> Mass Violence (gang, active shooting, etc) <input type="checkbox"/> Vehicle Victimization <input type="checkbox"/> Robbery <input type="checkbox"/> Stalking & Harassment	
<input type="checkbox"/> Survivors of homicide victims <input type="checkbox"/> Terrorism (domestic or international) <input type="checkbox"/> Victim of Disability <input type="checkbox"/> Victim of limited English proficiency	
Reason for Referral (Please describe mental health symptoms, behaviors and or areas of impairments that youth is experiencing) _____ Suicidal <input type="checkbox"/> Yes <input type="checkbox"/> No	

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CONFIDENTIAL PATIENT INFORMATION (SEE CALIFORNIA WELFARE AND INSTITUTIONS CODE SECTION § 5328)

Return all referrals & URI's to Shena Castillo at scastillo@countyofglenn.net or fax (530) 865-6483