



## Referral Form

Please Take a Moment to Complete the Following Information

\*\*\* Fax Referral Form to (800-549-4717) or email it to [Referrals@pacsla.org](mailto:Referrals@pacsla.org)\*\*\*

Client Information					
<b>Last Name</b>		<b>First Name</b>		<b>Middle Initial</b>	
<b>Other name(s) use or have used before</b>			<b>Mother's name</b>		
<b>Current Address</b>			<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Telephone Number</b> <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			<b>Other Phone Numbers</b>		
<b>Can we leave a message?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Good time to call back?</b>		<b>Gender</b> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/>	
<b>Birth Date</b>		<b>Social Security Number</b>		<b>English Speaking?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Preferred Language:</b>					
<input type="checkbox"/> Cantonese		<input type="checkbox"/> Japanese		<input type="checkbox"/> Spanish	
<input type="checkbox"/> Cambodian		<input type="checkbox"/> Korean		<input type="checkbox"/> Taiwanese	
<input type="checkbox"/> English		<input type="checkbox"/> Lao		<input type="checkbox"/> Thai	
<input type="checkbox"/> Filipino		<input type="checkbox"/> Mandarin		<input type="checkbox"/> Vietnamese	
<input type="checkbox"/> Hindi		<input type="checkbox"/> Other Chinese		<input type="checkbox"/> Other _____	
<b>What is the ethnicity of the person being referred:</b>					
<input type="checkbox"/> African-American/Black		<input type="checkbox"/> Hawaiian		<input type="checkbox"/> Other API	
<input type="checkbox"/> Amerasian		<input type="checkbox"/> Indochinese		<input type="checkbox"/> Samoan	
<input type="checkbox"/> Asian Indian		<input type="checkbox"/> Japanese		<input type="checkbox"/> Vietnamese	
<input type="checkbox"/> Cambodian		<input type="checkbox"/> Korean		<input type="checkbox"/> White/Caucasian	
<input type="checkbox"/> Chinese		<input type="checkbox"/> Laotian		<input type="checkbox"/> Unknown	
<input type="checkbox"/> Filipino		<input type="checkbox"/> Latino/Hispanic		<input type="checkbox"/> Other _____	
<input type="checkbox"/> Guamanian		<input type="checkbox"/> Native American			
<b>Birth County</b> <input type="checkbox"/> LA <input type="checkbox"/> Orange <input type="checkbox"/> Ventura <input type="checkbox"/> Other _____			<b>Birth State</b> _____		<b>Birth Country</b> _____



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<b>What is the Marital Status</b>				
<input type="checkbox"/> Never Married	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated
<b>What are the living arrangement?</b>		<b>Highest Grade Completed</b>		<b>Employment Status</b>
<input type="checkbox"/> Alone in house/apt	<input type="checkbox"/> W/immediate family	<input type="checkbox"/> _____ th grade (1-12)	<input type="checkbox"/> _____ year(s) of college	<input type="checkbox"/> Full-Time
<input type="checkbox"/> W/extended family	<input type="checkbox"/> W/friend	<input type="checkbox"/> Associate Degree	<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Part-Time
<input type="checkbox"/> W/unmarried partner	<input type="checkbox"/> W/foster family	<input type="checkbox"/> Master's	<input type="checkbox"/> Doctorate	<input type="checkbox"/> Cal-Works
		<input type="checkbox"/> Vocational Training w/HS diploma	<input type="checkbox"/> Vocational Training w/o diploma	<input type="checkbox"/> Student
		<input type="checkbox"/> No education		<input type="checkbox"/> Homemaker
				<input type="checkbox"/> Unemployed
				<input type="checkbox"/> Retired
				<input type="checkbox"/> Other
<b>Veteran?</b>			<b>Physical disabilities?</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Financial Information			
<b>Medical Coverage?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Insurer's Name</b>	<b>Insurance Card #</b>	<b>Issue/Effective Date</b>
<b>Number of Dependents?</b>	<b>Monthly Family Income?</b>		
<b>Primary Doctor?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Name of primary doctor:</b>		
<b>Source of income</b>			
<input type="checkbox"/> I work and receive salary	<input type="checkbox"/> Veteran's Administration	<input type="checkbox"/> Unemployment Insurance	<input type="checkbox"/> LA County General Relief
<input type="checkbox"/> Disability Insurance	<input type="checkbox"/> In-kind Care	<input type="checkbox"/> SSI	<input type="checkbox"/> Self-employed
<input type="checkbox"/> Other Public Assistance	<input type="checkbox"/> Other (e.g., retirement income)	<input type="checkbox"/> SSDI	<input type="checkbox"/> No income
<b>Occupation</b>	<b>Employer's Name</b>		
<b>Employer's Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Employer's Phone Number</b>		<b>Date Last Worked</b>	



## Referral Form

<b>Referral Information</b>		
<b>Who is the Referral Source?</b>		
<input type="checkbox"/> Self	<input type="checkbox"/> DPSS	<input type="checkbox"/> Regional Center
<input type="checkbox"/> Board and Care	<input type="checkbox"/> Family Member	<input type="checkbox"/> Religious Organization
<input type="checkbox"/> CalWORKs	<input type="checkbox"/> Friend	<input type="checkbox"/> School
<input type="checkbox"/> Collaboration	<input type="checkbox"/> Other Social Agency	<input type="checkbox"/> Substance Abuse Program
<input type="checkbox"/> Court	<input type="checkbox"/> Police	<input type="checkbox"/> Other _____
<input type="checkbox"/> DCFS	<input type="checkbox"/> Probation	
<b>Relationship to Client:</b> (if self) please skip to Emergency Contact Section		
<b>Contact/Caller's Name</b>	<b>Contact/Caller's Phone Number</b>	
<b>Is the Client Aware of this Referral?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Can We Contact the Client?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Best Way to Contact the Client?</b> <input type="checkbox"/> Cell: _____ <input type="checkbox"/> Work: _____ <input type="checkbox"/> Other: _____		

<b>Emergency Contact</b>			
Name	Relationship		Phone Number
Current Address	City	State	Zip

<b>Client Presenting Problem</b>
<b>Why is person being referred?</b>



## Referral Form

**Psychiatric History:**

How long has this presenting situation been a problem? \_\_\_\_\_

Individual reports presenting to any mental health agency previously (DMH agency/contract/private)

Yes     No

Individual reports being released from a psych hospital, jail/juvenile hall, mental health residential facility

Yes     No

Current medications including non-psychiatric (list names and other pertinent info such as compliance with meds)

If currently on meds, how much supply does person have?

Follow Up comments:

### CURRENT RISK AND SAFETY CONCERNS

(Please check)

- |   |   |
|---|---|
| <input type="checkbox"/> Current thoughts of self harm/suicide<br><input type="checkbox"/> Past thoughts of self harm/suicide<br><input type="checkbox"/> Prior suicide attempts<br><input type="checkbox"/> Probation involvement<br><input type="checkbox"/> Current / history of injuring animals<br><input type="checkbox"/> Recent trauma exposure<br><input type="checkbox"/> Recent job loss<br><input type="checkbox"/> Victim of violence / abuse<br><input type="checkbox"/> DCFS involvement | <input type="checkbox"/> Current thoughts of harming another person<br><input type="checkbox"/> Past thoughts of harming another person<br><input type="checkbox"/> History of homicide / manslaughter<br><input type="checkbox"/> History of injuring another person<br><input type="checkbox"/> School issues or IEP in place<br><input type="checkbox"/> Current substance use / abuse<br><input type="checkbox"/> Past substance use / abuse<br><input type="checkbox"/> Perpetrator of violence / abuse<br><input type="checkbox"/> Homelessness |
|---|---|



## Referral Form

**Has the person being referred:**

Thought about killing or hurting someone else?  Yes  No

Thought about ending your life or committing suicide?  Yes  No

Comment:

**Disability Description:**

- Not physically disabled/no significant disability
- Developmental disabilities
- Physical disability other than any of the above
- Speech impairment and physical impairment
- Physical impairment and conditions other than developmentally disabled
- No physical or mental disability
- Mental Disability
- Mental Disability/Blindness
- Mental disability/speech impairment
- Mental disability/Physical Impairment
- Mental Disability/Developmental Disability
- Not Stated/Un-reported
- Other \_\_\_\_\_

**\*Thank You\***

Please be advised that a referral to PACS does not guarantee that there is intake availability.  
 Please contact the intake person at 562-424-1886 to verify availability.

**\*\*\* Fax Referral Form to (800-549-4717) \*\*\***

**Los Angeles Office**  
 8616 La Tijera Blvd.  
 Suite 200  
 Los Angeles, CA 90045  
 (310) 337-1550

**Long Beach Office**  
 3530 Atlantic Ave.  
 Suite 210  
 Long Beach, CA 90807  
 (562) 424-1886

**Van Nuys Office**  
 6931 Van Nuys Blvd.  
 Suite 200  
 Van Nuys, CA 91405  
 (818) 989-9214