REFFERAL TO PRIMARY CARE

San Diego County Behavioral Health Services (SDCBHS)

SECTION A. REASON FOR REFERRAL	
☐ A) For physical healthcare - SDCBHS will continue to provide specialty mental health services.	☐ B) For total healthcare - SDCBHS no longer providing routine treatment. Available for psychiatric consult.

SECTION B. CLIENT INFORMATION and MENTAL HEALTH INFORMATION		
Last Name :	First Name:	Middle Initial:
AKA:		
Street Address:	Date of Birth:	☐ Male ☒ Female
City, State and ZIP:	Last Psychiatric Hospitalization: Date: None: ☐	
Telephone #:		
Current Mental Health Diagnosis:	Current Mental Health Symptoms:	
Current Mental Health and Non-Psychiatric Medications and Doses:		
Known Physical Health Problems:		

PLACE A COPY OF THIS FORM IN THE CLIENT'S MEDICAL RECORD

REFFERAL TO PRIMARY CARE

San Diego County Behavioral Health Services (SDCBHS

SECTION C. BEHAVIORAL HEALTH PROVIDER INFORMATION

Name, Organization OR Medical Group:	
Street Address:	City, State, Zip:
Telephone #:	Fax #:

SECTION D. BEHAVIORAL HEALTH CONTACTS FOR FURTHER INFORMATION

Psychiatrist:	Phone #:
Nurse:	Phone #:
Case Manager or Clinician:	Phone #:

SECTION E. PRIMARY CARE PROVIDER INFORMATION

Name, Organization OR Medical Group:	
Street Address:	City, State, Zip:
Telephone # :	Fax #:

SECTION F. ACCEPTED FOR TREATMENT OR REFERRED BACK TO SDCBHS

☐ **Patient accepted for physical heath treatment**

☐ **Patient accepted for psychotropic medication treatment**

☐ **Patient not accepted for psychotropic medication treatment and referred back due to:**

PLACE A COPY OF THIS FORM IN THE CLIENT'S MEDICAL RECORD