

Support and Advocacy for Young Adults in Transition Program (SAYAT)

REFERRAL FORM

Return this form by fax to (650) 368-9017

Or by mail to MHA, 2686 Spring St., Redwood City, CA 94063

CLIENT NAME: _____ REFERRAL DATE ____/____/____

Current Address _____ Phone _____

Mailing Address _____

Referring Agency _____ Phone _____

Referring Person _____ Phone _____

Demographics

Age ____ Birth Date ____/____/____ Gender _____ Race/Ethnicity _____ Marital Status _____

Soc. Sec. Number _____ Primary Language _____ Highest Education Level _____

Amount and Source of Monthly Income: _____

Medical Insurance Information: Medi-Cal ____ Kaiser ____ Other _____ None _____

What are the challenges and stressors the client is currently facing? Please describe how the SAYAT program can assist: _____

Are There Family Members We Can Contact? Yes ____ No ____

If yes, Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

Criminal Justice History: Yes ____ No ____ if yes, please list offenses, date of each offense, and current legal status (e.g. probation or parole).

Eligible for or Receiving Golden Gate Regional Center Services: Yes ____ No ____

If yes, describe services _____

Eligible for or Receiving Special Education Services: Yes ____ No ____

If yes, describe services _____

Mental Health Status

Diagnosis: Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Diagnosed by (and date of diagnosis, if known) _____

Is client receiving services from San Mateo County Mental Health Services? Yes ____ No ____

If yes, list Mental Health Number (MIS): _____

Primary Care Coordinator: _____ Phone: _____

If no, has client ever been referred for County Mental Health Services? Yes _____ No _____
If yes, please describe outcome of referral _____

Any previous psychiatric hospitalizations? Yes _____ No _____ If yes, how many? _____
Age at first hospitalization, if known? _____
Circumstances of most recent hospitalizations: _____

Current psychiatric medication: _____
Prescribing psychiatrist: _____
Substance Abuse History: Yes _____ No _____ if yes, describe: _____

Treatment: Yes _____ No _____
If yes, where and when: _____
Is the client presently using drugs or drinking? Yes _____ No _____ if yes, please describe: _____

If no, how long has he/she been clean and sober? _____
Suicide Attempts: Yes _____ No _____
If yes, please describe: _____

Date of most recent attempt ____/____/____
History of Violence towards self/others/property: Yes _____ No _____
If yes, please describe: _____

Date of most recent incident ____/____/____
History of Physical Abuse: Yes _____ No _____ if yes, please describe type and list age when abuse occurred, and relationship to abuser: _____

History of Sexual Abuse History: Yes _____ No _____ if yes, please describe type and list age when abuse occurred, and relationship to abuser: _____

Eating Disorders: Yes _____ No _____ if yes, please describe and list any treatment: _____

Other Information that will be helpful to know: (e.g., behavioral issues or problems, symptoms, coping mechanisms, learning disabilities, IQ, etc.): _____

Current and Past Living Situation(s)

Has the client been homeless*? Yes _____ No _____
**HUD defines homeless as either sleeping in an emergency shelter or sleeping in places not meant for human habitation (cars, parks, sidewalks, etc.) Or living in transitional housing for homeless persons. This would also include clients who face eviction within a week from a private dwelling unit and no subsequent residence has been identified and the client lacks the resources and support networks needed to obtain housing; or discharge within a week from an institution in which the client has been a resident for 30 or more consecutive days and no subsequent residence has been identified and he/she lacks the resources and support networks needed to obtain housing.*

Is the client chronically homeless*? Yes _____ No _____

**Chronically homeless is defined as continually homeless for one year or 4 episodes of homelessness in the past 3 years.*

Is the client currently homeless or in danger of becoming homeless within a week? Yes _____ No _____

Has the client ever been evicted? Yes _____ No _____

If answered yes to any of the above, please describe the circumstances: _____

Please describe the client's current living arrangement (i.e., who are they living with? Is it stable or safe?)

Employment

Employment History: Yes _____ No _____ if yes, please describe work experience (what type of work, how long employed, and current employer or reason for leaving): _____

Please attach employment and/or income verification to this referral

Any volunteer experiences? If yes, what type and how long: _____

Current Service Providers

(Names and Phone Numbers)

Case Manager	_____
Psychiatrist	_____
Therapist	_____
Probation Officer	_____
Occupational Therapist	_____
Voc. Counselor	_____
Primary Care Doctor	_____
Teacher	_____
Other	_____

MENTAL HEALTH ASSOCIATION
Support and Advocacy for Young Adults in Transition Program (SAYAT)
Authorization and Consent
For
Release of Confidential Information

I, _____, hereby authorize the Support and Advocacy for Young Adults in Transition Program (SAYAT) to have access to all medical / psychiatric / alcohol / drug records / police / health information and any other information from:

related to receiving SAYAT services.

I also authorize the SAYAT staff to provide information to the following agencies and individuals:

in an agreed upon plan of action.

I understand that I may revoke any portion of this consent at any time, except for information already obtained or acted upon. I further understand that by revoking this consent I may become ineligible to receive services. If not revoked in writing earlier, this consent shall be valid for an 18-month period from the date it is signed.

Client Signature

Date