Behavioral Health Services
1061C–Referral Form

Call or Fax to:
Children and Family Services
2440 Sixth Street, Eureka, CA 95501
Phone: (707) 268-2800 Fax: (707) 445-7270

Date Faxed:
Date Received:

Information for person being referred:

Last Name:_____ First Name:_____ MI:___

DOB:_____ Age:_____ School:_____

SSN:_____ Medi-Cal #:_____

Parent/Guardian Name:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Best time to contact: ☐AM ☐PM

Dependent of Court: ☐ (yes)
Lawyer:
Social Worker:
Primary Care Provider:
Probation Officer:

Address:_____ City:_____ Zip:_____

Presenting Issues:

Current Medications (if applicable):_____

Referral Source:

Name:_____ Agency Affiliation:_____

Address:_____ City:_____ Phone:_____

Requesting Mental Health Services Assessment For:

☐Outpatient Counseling Services ☐Medication Services ☐Level of Medical Necessity
☐Second Opinion ☐Other:_____

Office Use:

Medi-Cal:	Clinician:	Case #:
Logged:	Assessment:	