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:	

CONFIDENTIAL PATIENT INFORMATION (SEE CA W & I CODE 5328, 42 CFR PART 2)
DHHS–BH FORM#1061C (Rev 5/26/20)