SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Referral for Higher Level of Care – Youth 6-17

Please continue working with your client until you have confirmed that you client has been accepted and connected to appropriate services. In some cases, the client may remain open to you for therapy**. This referral is not for emergency services.** If there are safety concerns, call 911 or refer to nearest emergency room**.** Should be used by HPSM mild to moderate network providers.

Date:	**Referring Provider/Agency:**	**Phone:**
Name of Client: *Name of Guardian/s:*	**DOB**:	**HPSM ID or CIN:** **Diagnosis:**
Legal Guardian's Phone # **Ok to leave detailed message:** ☐ **Y** ☐ **N**	**Guardian notified of referral:** ☐ **Y** ☐ **N**	**Language of Client:** **Legal Guardian/s:**
I agree to continue to provide services until member is transitioned: ☐ **Y** ☐ **N**	**Other BH provider Name and Phone**	**Foster care placement** ☐ **Y** ☐ **N**
Current Psychiatric Medications:		
Reason for referral *(include case management or medication needs, please attach additional documentation)*		
Safety issues *(Recent SI/HI, psychiatric hospitalizations, Open CFS case etc.)* **:**		
Name of School:	**IEP info:**	

Client must meet four (4) or more criteria from List A, or one (1) from List B to be eligble for higher level of care. Check all that apply.

List A (Mild-Moderate) Up to 3 from this list	**List B (SED) 1 from this list or 4+ from list A**
☐ Up to two PES visits within last 6 months	☐ Two or more psychiatric hospitalizations within past 12 months
☐ Mild to Moderate symptoms of depression and anxiety (excessive sadness, crying, SI w/o plan, irritability, self-isolation, excessive worries)	☐ Functionally significant, non-substance induced paranoia, delusions, hallucinations, mania, or dissociative symptoms that significantly interfere with current functioning
☐ Physically aggressive, assaultive, self-destructive, oppositional behavior, bullying, or victim of bullying	☐ Self-injurious behaviors with intent to cause harm within past 6 months
☐ Co-morbid mental health and substance use conditions	☐ Suicidal/homicidal pre-occupation with plan and intent within past 12 months
☐ Impulsivity, hyperactivity, sensory issues negatively impacting functioning	☐ At risk of losing home or school placement due to mental health condition
☐ Trauma, sexual abuse, sexualized behaviors, victim of human trafficking **not requiring Specialty team services**	☐ Trauma, victim of Human Trafficking, sexual exploitation sexualized behaviors requiring Specialty team services
☐ Recent loss, significant family stressors, domestic violence	☐ Primary caregiver's functioning significantly impaired-may require case management
☐ Eating disorder without medical complications	☐ Eating disorder with medical complications
☐ CFS case within past 6 months	☐ Currently in foster care placement, active CFS/Probation case with potential to require collaboration/support from
☐ Excessive truancy, failing or missing school due to a mental health condition	☐ Transition Aged Youth with psychotic symptoms and sign indicated in the Prodromal Questionaire (PQ-B)

Access: 1-800-686-0101. Please Fax to Access Call Center: 650-596-8065 and attach relevant supporting documents.