

TRI-CITY MENTAL HEALTH CENTER

**OLDER ADULTS
FIELD-CAPABLE CLINICAL SERVICES
REFERRAL FORM**

REFERRAL INFORMATION

DATE: _____

LAST NAME: _____ FIRST NAME: _____ PREFERRED LANGUAGE: _____

DOB: _____ RACE/
ETHNICITY: _____ GENDER: __M __F

ADDRESS: _____ CITY: _____ ZIP: _____

PHONE: (____) _____ CURRENT LIVING SITUATION: _____

INSURANCE: __MEDI-CAL __MEDICARE __V.A. __PRIVATE __NONE

PRIMARY CONTACT: _____ RELATIONSHIP: _____

PREFERRED LANGUAGE: _____ PHONE: (____) _____

CONSERVATOR: __YES __NO IF YES, WHOM?: _____

REFERRAL SOURCE

AGENCY: _____ CONTACT PERSON: _____

PHONE: (____) _____ FAX: (____) _____ EMAIL: _____

Individual currently receiving services, either within or outside your agency?: __YES __NO

If yes, please identify: _____

Other Agency Involvement?: __HMO __Adult Protective Services __GR/DPSS __Office of Aging

Has individual been referred to any other programs, please identify: _____

ELIGIBILITY GUIDELINES INFORMATION

A. Individual is age 60 or older?: Yes No (If individual is not 60+, please specify age: _____)

B. CHECK ONE OF THE FOLLOWING:

Individual has a serious or persistent mental illness for which they are currently being treated or who has previously been treated

Individual has mental health symptoms that are not severe or persistent but is accompanied by a functional impairment in activities of daily living or instrumental activities of daily living

Individual is at risk of losing or not attaining stable or safe living arrangement, risk of losing or inability to access needed services (including caregiver services), risk of losing independence due to mental health symptoms

Provide details for any checked items:

C. CHECK ONE OF THE FOLLOWING:

Other senior service agencies have been contacted/identified, but are not available to provide appropriate/relevant services to this individual

Individual cannot otherwise be appropriately served by another senior service agency

Provide details for any checked items:

SPECIFIC REASON FOR REFERRAL

Referrals with Dementia are not able to benefit from this program and are better referred to their MD or a neurologist.

A. Mental Health Symptoms:

Please check all that apply: Depressed mood

Suicidal thoughts/comments

Anxious mood Suspicious of others

Aggressive thoughts/behavior

Strange/unusual behavior Inappropriate sexual acts

Recent or past traumatic event

Please explain any checked items:

SPECIFIC REASON FOR REFERRAL
CONTINUED

B. Other Related/Relevant Issues of Concern:

Please check all that apply: Isolated/Homebound History/risk of abuse or neglect

Substance/Alcohol Abuse Medical problems/conditions

Please explain any checked items:

You may direct any questions or fax this referral form to:

Tri-City Mental Health Center
Field-Capable Clinical Services
Attention: Jan Brady, LMFT
Fax: (909) 865-9281
Phone: (909) 623-6131
Email: jbrady@tricitymhs.org

*Additional referral forms can be downloaded at tricitymhs.org