

IMPORTANT REMINDERS

- » We are working to find the right services with the right provider and improving access to services. You no longer need to worry about choosing the program; we will figure out the best fit given what you tell us about the child.
- » **For Alameda County Medi-Cal:** we can only serve a child or youth with moderate/severe symptoms.
- » **Therapy services are mostly limited to children or youth with Alameda County Medi-Cal.**
- » **Children with mild/moderate range of symptoms:** Please refer to ACCESS 1-800-491-9099.
- » **We have limited services for private insurance in Psychiatry only.** Please have families check with the insurance company to see if we are contracted or in-network before referring for private insurance patients.

REFERRAL REQUIREMENTS

- » **Parents/guardians need to sign an Information/Consent for Referral Form in order for us to process the referral.**
- » **An incomplete referral form will be returned and cannot be processed.**

We look forward to working with you and the family to support the child's needs.

For appointments with a Developmental Behavioral Pediatrician:
Call (877) UC-CHILD (822-4453) and request an appointment with Developmental Medicine



SERVICES

EARLY INTERVENTION SERVICES (EIS)

Age: 0-5 for new referrals

Specialties: Behavioral, emotional and developmental difficulties of infancy and early childhood; parent-infant interaction challenges; home visiting

Programs: Fussy Babies, TGIF, CARE, FIRST

Insurance: Alameda County Medi-Cal

PSYCHOLOGICAL SERVICES

Age: 2-21 for psychological testing; 3-21 for psychotherapy

Specialties: Psychological testing (with prior Alameda County approval and referred by current mental health clinician) and outpatient psychotherapy including individual, group & family therapy

Insurance: Alameda County Medi-Cal

PSYCHIATRY

Age: 5-18 for new referrals

Specialties: Psychiatric evaluation and psychopharmacological management.

Insurance: Alameda County Medi-Cal and limited capacity to accept commercial insurance and self-pay.

SCHOOL-BASED HEALTH CENTERS

- McCLYMONDS/CHAPPELL HAYES
- YOUTH UPRISING/CASTLEMONT

Age: 12-21

Specialties: Outpatient psychotherapy including individual, family and group psychotherapy with adolescents and transitional aged youth. Psychiatric evaluation and psychopharmacological management.

Insurance: Alameda County MediCal

RELEASE OF INFORMATION/ CONSENT FOR REFERRAL

I HEREBY AUTHORIZE THE USE AND/OR DISCLOSURE OF MY HEALTH AND MENTAL HEALTH INFORMATION TO:

- UCSF Benioff Children's Hospital Oakland and/or
Mental Health & Child Development Services
747 52nd Street
Oakland, CA 94609
- UCSF Benioff Children's Hospital San Francisco
1975 4th Street
San Francisco, CA 94518

After reviewing your referral, we may forward it to our specialty programs in San Francisco.

I agree to having the referral sent to San Francisco for consideration

Parent/Caregiver Initials

PATIENT INFORMATION

Patient's Name _____ Date of birth _____

PERSON/ORGANIZATION RELEASING THE PATIENT'S HEALTH AND/OR MENTAL HEALTH INFORMATION

Name/Organization _____

Street Address _____

City _____ State _____ Zip _____

PARENT/GUARDIAN/CAREGIVER AUTHORIZATION

Name of patient's legal representative (parent or guardian) _____

Signature _____

Phone _____ Date _____

Name of patient's personal representative (if applicable) _____

Relationship to patient _____

Signature _____

Phone _____ Date _____

I have the right to a copy of this authorization. Copy requested: No Yes

This authorization shall be valid for one (1) year from the date above.

**All sections of the referral need to be completed so that we can process the referral as quickly as possible.
Fax this form, the release of information/consent & all relevant paperwork
(i.e., IEPs, past testing, screening forms, Vanderbilts, etc) to (510) 985-2202.**

1. PATIENT INFORMATION

Patient's First Name _____
 Last Name _____
 DOB ____/____/____ MR# _____
 Age _____ Gender _____
 School _____

2. CAREGIVER INFORMATION

Caregiver Name _____
 Parent Legal Guardian Foster Family Adopted Other _____
 Street Address _____
 City _____ State _____ Zip _____
 Phone (_____) _____
 Interpreter needed? No Yes: Parent Patient
 Language _____

3. INSURANCE INFORMATION

Subscriber Name _____
 DOB ____/____/____ SSN _____
 Subscriber ID _____
 Patient's SSN _____
 Medi-Cal ID _____
 County _____
 Medi-Cal CFMG Other-Carrier _____
 Insurance phone (_____) _____

4. REFERRER CONTACT INFORMATION

Referral date ____/____/____ Family informed of referral? Yes No
 Referred by _____
 Phone (_____) _____ Fax* (_____) _____
 Office name _____ City _____

*Without your fax number, we will not be able to provide referral updates

5. PRIMARY CARE PROVIDER

Same as referrer UCSF Benioff Children's Hospital Oakland
 Provider Name _____
 Clinic Name _____
 Phone (_____) _____ Fax (_____) _____

6. CURRENT CONCERNS & REASON FOR REFERRAL

7. SERVICES REQUESTED

- Mental Health Evaluation
- Psychiatric Medical Evaluation with MD/ NP
- Therapy: Child and/or Family

8. CURRENT SYMPTOMS/CONCERNS

Please check all that apply:

- Hurting themselves /self-harm
 - Suicidal thoughts (If in imminent threat of harm, call 911)
 - Psychiatric hospitalizations in last year
 - Seeing or hearing things others don't / Psychotic symptoms
 - Aggression towards self or others
 - Eating disorder with medical complications
 - Age inappropriate sexualized behaviors
 - Significant parent/child attachment concerns (0-5 years old)
 - Difficult to soothe / Excessive crying (0-5 years)
 - Frequent Tantrums
 - Trauma / Loss / Grief
 - Separation/loss of primary caregiver
 - History of neglect/Abuse
 - Can't sit still / too active/impulsive
 - Difficulty following directions or paying attention
 - Withdrawn/isolative
 - Anxious / Worried / Very Nervous
 - Sad / Depressed
 - Sleeping concerns
 - Eating concerns without medical complication
 - Parent/Child relationship interaction problems
 - Not making friends / Poor social skills
 - Not doing well in school / Poor attendance
 - Not meeting milestones / Developmental delay*
 - Cognitive Delay Motor Delay
 - Nonverbal Learning disability
 - Trouble communicating / Speech-Language delay
- *All children with developmental symptoms must also have behavioral/emotional symptoms to be eligible for services

9. CURRENT SITUATION

Please check all that apply:

- CPS report in last 6 months
- Court dependent/ward of the court
- At risk of losing home/child care placement due to behavior
- Currently in out-of-home foster placement
- Juvenile probation supervision with current placement order

10. CURRENT SERVICES

- Regional Center Services
- Speech Therapist, OT, PT, SST/504/IEP
- Therapy: Provider _____
- Psychiatrist: Provider _____
- Developmental Behavioral Pediatrician: _____

11. OTHER MAJOR MEDICAL CONCERNS None

