New Alternatives, Inc. CCYP Program Referral

Center for Child & Youth Psychiatry

Email: CCYPreferral@newalternatives.org
Fax to: 858-634-1101
Eligibility: MediCal and unfunded Children and Youth
Updated:12.2.2022

COMPLETED BY CCYP ADMIN ONLY

Date Received: _____

Date Logged: _____

Status: _____

REFERRAL SOURCE **DATE:** _____

Referring Provider Name: _____ Agency: _____

Contact #: _____ Email: _____

DEMOGRAPHIC INFORMATION **Case ID#**:_____

Child or Youth Legal Name:_____Cell Phone # *(if applicable)*: _____

Preferred Pronouns: _____ Preferred Name: _____SSN:_____

Placement: ☐Biological Family ☐Family Resource Family ☐Other: _____

If foster parent, authorized to give consent? ☐Yes ☐No (*If no, who can give consent?):*_____

Child or Youth's Address: _____ City: _____ Zip Code: _____

Sex Assigned at Birth: ☐Male ☐Female ☐Other: _____ Age: _____ DOB: _____

Ethnicity: _____ Language: ☐English ☐Spanish ☐Other: _____

Parent(s)/Caregiver(s) Name: _____ Relationship: _____

Best Contact(s) #: _____ Email(s): _____

Availability/Best time to contact:_____

Parent Address: ☐Same as above ☐Other: _____

CWS or Probation Involvement? ☐Yes ☐No Current JV220? ☐Yes ☐No Expiration Date: _____

CWS/PO Name: _____ Contact #:_____ Fax #:_____

MEDICAL

Health Insurance Medi-cal #: _____Other Health Insurance: _____

Current PCP: _____ PCP Group/Office: _____Phone #: _____

Relevant Medical Diagnosis: _____

Alcohol/Drug Concerns: ☐Yes ☐No (if yes, explain): _____

_____

CLINICAL INFORMATION

Reason for Referral: _____

Current/Most Recent Psychiatrist: _____ Contact #: _____

Primary Diagnosis: _____ Secondary Diagnosis: _____

Other Diagnosis: _____

List all Prescribed Medication including dosages:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Relevant Social Factors to Note: _____

_____

_____

Child or Youth's Strengths: _____

_____

Current behaviors/symptoms that are of concern, it any: _____

_____

_____

PSYCHIATRIC/MENTAL HEALTH TREATMENT & HISTORY

Previous Symptoms & Diagnosis: _____

_____

_____

Prior Psychiatric Hospitalization? ☐Yes ☐No (if yes, how many times and why): _____

_____

_____

Prior Mental Health Services:

Program: _____ Program: _____

Program: _____ Program: _____

ADDITIONAL SUPPORTIVE INDIVIDUALS/EMERGENCY CONTACTS

Name:	Relationship:	Phone:	Emergency Contact?
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No

Additional Information: _____

_____

_____

_____

COMPLETED BY CCYP ADMIN ONLY

Approved

Date Caregiver Contacted: 1st: _____ 2nd: _____ 3rd: _____

Assigned Clinician: _____ Intake Date: _____ Time: _____

Notes: _____

_____

Denied

Reason: _____

_____

Date Referring Party Notified: _____ Date NOABD Letter Mailed: _____

Notes: _____

_____