# STRTP Referral Form

Email: CCYPreferral@newalternatives.org
Fax to: 858-634-1101
*Updated: 08.31.2022*

***Completed by CCYP Admin Only***
Date Received: _____
Assigned Psychiatrist: _____
Initial Psych: _____
Assigned AC: _____
BHA Appt.: _____

**Today's Date:** _____ **STRTP:** _____ **STRTP DOE:** _____

The following items are required for this referral and will be considered incomplete if not provided. CCYP will not schedule an Initial Psychiatric Evaluation until all items are received

- ☐ JV220/JV223
- ☐ Psychiatric & Medication History
- ☐ IEP or 504 Plan, *if applicable*
- ☐ Recent CANS & Caregiver/Youth PSC
- ☐ 04-24
- ☐ History of Mental Health Treatment
- ☐ Health and Education Passport
- ☐ Youth Transition Self-Evaluation, *if applicable*
- ☐ Current MAR
- ☐ Labs Completed within 12 Months
- ☐ Proof of Guardianship/Legal Consent
- ☐ COPY of Health Insurance Card

*If **ANY** item above is missing, please explain why:* _____

_____

_____

**DEMOGRAPHIC INFORMATION**

Child or Youth's Legal name: _____ Case ID #: _____

Preferred Pronouns: _____ Preferred Name: _____ SSN: _____

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

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

STRTP Clinician: _____ Phone #: _____ Email: _____

CWS Contact: _____ Phone #: _____ Email: _____

Probation involvement? ☐ Yes ☐ No *(if yes, please provide the following information below)*

REJIS #: _____ PO Contact: _____ Phone #: _____

Person authorized to consent for services: _____ Relationship: _____

Phone #: _____ Email: _____

Does youth have parent involvement? ☐ Yes ☐ N o *(if yes, please complete parental information below)*

Parent Name: _____ Phone #: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Other agency involvement? ☐ Yes ☐ No (*if yes, which agencies):* _____

Other mental health services being provided: _____

**MEDICAL/MENTAL HEALTH INFORMATION & HISTORY** *(Please attach a copy of youth's health insurance card)*

Medi-Cal #: _____ Other 3rd Party Health Insurance: _____

Current Primary Care Physician: _____ Phone: _____

Medical health history/concerns, if any: _____

_____

Current psychiatrist: _____ Phone: _____

Current DSM-V diagnosis: _____

Client's Strengths: _____

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

_____

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

Allergies and/or drug reactions: _____

_____

**Medication History *(please list current/most recent medications first):***

**Please note, the MAR is a required item when submitting the referral and the section below is CANNOT be used as a substitute.*

| Medication Name/Dosage | Prescribing Physician | Start & End Date | Reason for discontinuation, *if applicable* |
|---|---|---|---|
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |
| **4.** | | | |

**Prior Mental Health Services:**

| Program/Placement Name | Services Provided | Start & End Dates |
|---|---|---|
| **1.** | | |
| **2.** | | |
| **3.** | | |
| **4.** | | |

Additional Information: _____

_____

_____

_____