SANCTUARY CENTERS
SANTA BARBARA
*Improving one life at a time.*

*Instructions for Referral to **Mental Health Inpatient Care - Residential** (Sanctuary House):*

1. A clinical professional may complete and submit the **Referral Form** on the following pages.
2. Applicant or representative must complete the **Functional Capability Assessment** form that is available for download from this page: https://sanctuarycenters.org/programs/mental-health-inpatient-care/
3. Submit the **Referral Form** and the **Functional Capability Assessment** together to:

   Attn: Clinical Director
   Sanctuary Centers
   PO Box 551, Santa Barbara, CA 93102

   Telephone: 805.569.2785
   Fax: 805.563.1977

*Instructions for Referral to **Mental Health Outpatient Care** (Arlington Day Treatment Center):*

1. A clinical professional may complete and submit the **Referral Form** on the following pages.
2. Submit the **Referral Form** to:

   Attn: Outpatient Care Program Director
   Sanctuary Centers
   PO Box 551, Santa Barbara, CA 93102

   Telephone: 805.569.2785
   Fax: 805.564.3448

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# REFERRAL FORM

*(* = Required Information)*

*Referral for: ☐ Mental Health **Inpatient** Care (Residential) ☐ Mental Health **Outpatient** Care

*Referring Agency: _____ *Phone: _____

*Person completing this form: _____ *Date: _____

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**Authorization:** ***"I authorize the transmission of information concerning my history, care and treatment to authorized personnel at Sanctuary Centers. This authorization is granted on condition that due care be exercised at all times with respect to my rights to privacy and confidentiality. This authorization is not a waiver of any privilege conferred on me by law or regulation."***

***Signed:** _____ ***Date:** _____

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*Client Name: _____ *Phone: _____

*Address: _____

*Date of Birth: _____ *Age: _____ *Gender: _____

*Marital Status: _____ *Race: _____ *Ethnicity: _____

Religion: _____ *Social Security #: _____

Medi-Cal #: _____ Other Health Insurance: _____

*Source of Income: ☐ SSI: $_____ ☐ Family: $_____

☐ Other: $_____, Description: _____

*Income Approved? ☐ Yes ☐ No

Conservatorship: ☐ Finances ☐ Personal Expiration Date: _____

Conservator Name: _____ Phone: _____

Parent/Guardian Name(s): _____

Marital Status: _____ Phone Number(s): _____

## ***CLINICAL INFORMATION:***

*Diagnostic Impression:

A) _____ _____
DSM-5 Code DSM-5 Description

B) _____ _____
DSM-5 Code DSM-5 Description

C) _____ _____
DSM-5 Code DSM-5 Description

D) _____ _____
DSM-5 Code DSM-5 Description

E) _____ _____
DSM-5 Code DSM-5 Description

F) _____ _____
DSM-5 Code DSM-5 Description

G) _____ _____
DSM-5 Code DSM-5 Description

## ***I. PRESENTING PROBLEMS:***

*A. Current difficulties and brief description of onset of emotional problems. Why is this referral being made?

*B. Mental Status: Appearance, affect, orientation, mood, preoccupation, thought content and process.

*C. Psycho-social Stressors: Assess factors that contribute to current status.

*D. Family History: Assess relationship, past and present, with family.

*E. Social History: Assess relationship, past and present, with friends, other social agencies, etc. Include any information available on education history, work history.

*F. Current Living Situation (not hospital):

*G. Drug and/or Alcohol Abuse (past or present):

*H. Suicide Attempts and/or Ideation (include means of attempt, past or present):

## ***CRIMINAL HISTORY***

*I. Previous engagement in violent or other anti-social activity:

*Please assess current potential for violence:

*J. Current Legal Status (probation, court date(s), charges pending):

## ***II. TREATMENT HISTORY:***

*A. State or Other Psychiatric Hospitalizations: Include locations, dates and durations, if information available. Include drug treatment history. Describe precipitant factors.

*B. Therapy contacts: Past and present, in addition to referring agency. Include outpatient programs.

*C. Physician Information:

Last Name: _____ First Name: _____

Address: _____ Phone: _____

*D. Psychiatrist Information:

Last Name: _____ First Name: _____

Address: _____ Phone: _____

## ***IV. MEDICATION EVALUATION/MEDICAL CONCERNS:***

*A. Medication: Type, dosage, length of time on these medications.

*B. Drug Allergies:

*C. Other Allergies:

*D. Describe General Physical Health and Medical Concerns:

*E. Dietary Restrictions:

*F. Date of last Physical Examination: _____ *Results: _____

*G. Medical Devices (e.g. contact lenses, IUD, pacemaker, etc.):

*H. Seizure History & Activity in the Past Year:

## ***V. TREATMENT PLANNING:***

*A. Describe treatment plan developed by your agency or which you would consider appropriate for this client:

*B. What areas would you consider to be potential problems for this client in a group living situation (cooking, cleaning, use of free time, etc.)?

**Signed by: _____ Date: _____**

**FOR ADDITIONAL COMMENTS, PLEASE USE ADDITIONAL SHEETS**

PLEASE ATTACH ALL APPROPRIATE DISCHARGE MATERIAL