DIVISION OF MENTAL HEALTH & CHILD DEVELOPMENT

REFERRAL OVERVIEW

UCSF Benioff Children's Hospital Oakland

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

UCSF Benioff Children's Hospitals
Oakland | San Francisco

REQUIRED DOCUMENT: Submit With Referral Form

DIVISION OF MENTAL HEALTH & CHILD DEVELOPMENT

RELEASE OF INFORMATION/ CONSENT FOR REFERRAL

747 52nd St., Oakland, CA 94609 • 510-428-8428 • www.childrenshospitaloakland.org

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.

UCSF Benioff Children's Hospital Oakland

MENTAL HEALTH & CHILD DEVELOPMENT REFERRAL FORM

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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

_____

_____

_____

_____

SEPT 2018

Made accessible 3/24