VENTURA COUNTY BEHAVIORAL HEALTH

A Department of Ventura County Health Care Agency

Instructions for completing Referral for VCBH Mental Health Services Post Inpatient Psychiatric Hospital, Crisis Stabilization Unit, or Crisis Residential Facility

STEP 1: Complete the information on the Consent Page. Have the individual or Legally Authorized Representative (LAR) (for minors and conserved adults) read and sign the consent for referral statement on the Consent Page in the appropriate language. If the individual or LAR is not immediately available to sign the consent, there is a space to indicate that the individual/LAR is aware of the referral and has given verbal consent.

STEP 2: Fax or email the completed Consent Page AND Required documents to VCBH at Access@ventura.org

Required:

- Psychiatric Evaluation
- History and Physical
- Projected/Planned Discharge Date

If available:

- Labs
- List of medications and quantity
- Discharge summary

PLEASE NOTE: Referrals WILL NOT be processed until all required items in Step 2 are complete

STEP 3: VCBH will triage the referral to determine whether the individual likely meets criteria for VCBH mental health specialty services and will contact the referring party with the outcome.

If you need assistance with a referral, an update regarding the referral status, or to provide more information regarding the referral, please contact VCBH via the contact information below. Thank you for your collaboration!

VCBH Access & Outreach Division
1911 Williams Drive, Suite 165
Oxnard, CA 93036
Phone 805-981-4233
Fax 805-981-9268
Please click email button to submit to: Access@ventura.org

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CONSENT PAGE

Access@ventura.org

Referral / Screening Source

Date of Referral: _____ Referring Person: _____

Phone Number: _____ Fax Number: _____

Referring Agency: ☐ Hillmont IPU ☐ Vista Del Mar IPU ☐ CRT ☐ CSU ☐ Other: _____

If individual is younger than 21 years old, please check if:

☐ Has been exposed to trauma ☐ is currently or has a history of involvement in the Child Welfare System

☐ Is currently or has a history of involvement in the Juvenile Justice System ☐ Is experiencing homelessness

Information of Individual

Last Name: _____ First Name: _____ SS#: _____

Ethnicity: ☐ Black ☐ Latino ☐ White ☐ Other: _____ ☐ M ☐ F ☐ Other

Primary Language: ☐ English ☐ Spanish ☐ Other: _____ Age: ____ DOB: _____

If relevant, Legally Authorized Representative (LAR) Name: _____

Relationship to Individual: _____ LAR Primary Language: ☐ English ☐ Spanish ☐ Other:

Phone: Home _____ Cell _____ Work _____

Address: _____ City: _____ Zip: _____

Insurance Status: ☐ Medi-Cal # _____ ☐ No Insurance ☐ Private Insurance ☐ Medicare

Special Status: ☐ Veteran ☐ Parolee ☐ Conserved

☐ Court dependent minor (CPS) ☐ Ward of the Court (JUV. Probation)

Name and contact number of Conservator/Social Worker/Probation officer: _____

Referral Information

Reason for Referral: _____

Safety/Risk Issues (check if individual either is currently presenting with these symptoms or in the last 6 months)

☐ Suicidal thoughts/statements ☐ Homicidal thoughts/violent behavior ☐ Hallucinations/Delusions

☐ Property destruction ☐ Unable to take care of basic self care needs ☐ Fire setting

IPU/CSU/CRT Discharge Date: _____ Individual being discharged to CRT ☐ Yes ☐ No

Consent for Referral Statement

☐ ***English Statement:*** I hereby give consent for Ventura County Behavioral Health (VCBH) to exchange and release information from this screening with an assigned VCBH provider or affiliated private provider in order to evaluate me / my child for mental health services. I also authorize VCBH to update the referring party regarding the status of the referral. I understand that I will be contacted within 7 days by the assigned provider. If I have not been contacted within 7 days or am unsatisfied with the assigned provider, I will call (805) 981-4233.

☐ ***Spanish Statement:*** Por la presente doy consentimiento para que Ventura County Behavioral Health (VCBH) intercambie y de información de esta breve evaluación a un proveedor de VCBH asignado o proveedor privado afiliado para poder evaluar a mi / mi niño(a) para servicios de salud mental. También autorizo que VCBH provee información sobre la derivación a la agencia que hizo la derivación. Yo entiendo que se van a poner en contacto conmigo en menos de 7 días para asignar a un proveedor. Si no se han puesto en contacto conmigo en 7 días o menos o si no estoy satisfecho con el proveedor asignado, voy a llamar al (805) 981-4233.

_____ _____

Signature of Individual Accessing Care LAR Signature

Individual is aware of referral: ☐ Yes ☐ No

Phone consent from: ☐ Individual ☐ LAR

_____

Staff Signature (To verify phone consent obtained)