Mental Wellness Center

RECOVERY • EDUCATION • FAMILY SERVICES

Mental Wellness Center
(Legal name: Mental Health Association in Santa Barbara County)
617 Garden Street, Santa Barbara, CA 93101
805-884-8440 (tel.) • 805-884-8445 (fax)

Recovery Learning Center / Fellowship Club Referral Form

AUTHORIZATION: "I authorize the release of information concerning my history, care, and treatment to authorized personnel at the Mental Wellness Center from ____/____/____ to ____/____/____.
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."

Client Signature: ______________________________ Date: ______________

Referral Information *Entire form must be completed by a mental health professional to open client for services.*

Referring Agency: ______________________________ Phone: ______________

Clinician: ______________________ Phone: ______________ Staff ID#: __________

Psychiatrist: ______________________ Phone: ______________ Staff ID#: __________

Client Name: ______________________ Phone: ______________ ID#: __________

Client Address: ____

Date of Birth: __________ Age: _____ Sex: ______ Marital Status (circle one): S M D W SSN:______________

Source of Income: SSI ☐ Family ☐ Other ☐ Pro Pay ☐ Conservatorship? Yes ☐ No ☐

Race (optional): ______________ Religion (optional): ______________ Language(s) Spoken:______________

Living Situation: ______________ Employment Status: ______________ Education/Job Training: ______________

Emergency Contact: ______________________________ Phone: ______________

Diagnoses (please include all diagnoses in order of priority): ______________________________

____ Trauma? Yes ☐ No ☐

Substance Use/Dependence: Yes ☐ No ☐ Unknown ☐ Substance(s): ______________________

Any serious medical conditions: Yes ☐ No ☐ Unknown ☐ Medical Alert: ______________________

Does Client Have a History of . . .

Criminal Justice System Involvement?	Yes ☐	No ☐	Unknown ☐
Assaultive Behavior (verbal and/or physical)?	Yes ☐	No ☐	Unknown ☐
Theft?	Yes ☐	No ☐	Unknown ☐
Fire Starting?	Yes ☐	No ☐	Unknown ☐
Resistance to Authority?	Yes ☐	No ☐	Unknown ☐
Wandering or Running Away Behavior?	Yes ☐	No ☐	Unknown ☐
Suicidal Gestures and/or Attempts?	Yes ☐	No ☐	Unknown ☐

Why (symptoms, stressors, support issues)? ______________________________

What Tends to Stabilize Client? ______________________________

What Tends to De-Stabilize Client? ______________________________

Bio-psycho-social: What other unique biological, psychological or social issues should we be aware of?______________

____

Goals: ____

Referring Person's Signature: ______________________________ Date: ______________