STARTS Referral Form

Please Print

Phone (800) 704-0900 Fax to (408) 938-4536

SANTA CLARA COUNTY Behavioral Health Services

1. REFERRAL SOURCE

Referring Agency / School:	Program Name / District:	Referring Person:
Referring Person's Phone:		Referring Person's Email:
Reason for Referral *(please explain on additional paper if more room is needed):*		

2. PRIMARY CAREGIVER INFORMATION

Full Name:	Relationship: ☐ Parent ☐ Grandparent ☐ Foster Parent/ Other: Legal guardian? ☐ Same ☐ Name if not:	Gender ☐ F ☐ M
Ethnicity: *(mark one)* ☐ Asian ☐ Hispanic ☐ Alaska Native or American Indian ☐ Multiracial ☐ White ☐ Black/African American ☐ Other:	Primary Language: *(mark one)* ☐ English ☐ Spanish ☐ Vietnamese ☐ Other:	
Address: City: Zip:	Home Phone: Work Phone: Cell Phone:	Best time to call:

3. REFERRED CHILD INFORMATION *(age 0-5 years only)*

Full Name: Sibling/Siblings referred: ☐ Yes ☐ No	DOB: (MM/DD/YY)	Gender: ☐ F ☐ M	Check if child has: ☐ FSP ☐ IEP ☐ N/A or UK
Ethnicity: *(mark one)* ☐ Asian ☐ Hispanic ☐ Alaska Native or American Indian ☐ Multiracial ☐ White ☐ Black/African American ☐ Other:		Primary Language: *(mark one)* ☐ English ☐ Spanish ☐ Vietnamese ☐ Other:	

3A. CHILD'S HEALTH INSURANCE: ☐ No Insurance ☐ Medi-Cal ☐ Healthy Kids ☐ Valley Health Plan ☐ Other:

Health Insurance ID #: **Primary Care Physician Name** *(IF AVAILABLE):*

Referring for Triple P? ☐ Y ☐ N **If YES, what level?** ☐ L2 ☐ L3 ☐ L4 ☐ L5 ☐ Unknown or Not Sure

3B. CHILD CONCERNS AND RISK FACTORS : ***(including concerns of caregivers and/or teachers)*** *(mark all that apply)*

☐ None/Unknown ☐ Fine Motor ☐ Gross Motor ☐ Speech/Language ☐ Problem Solving/Cognitive ☐ Severe Aggression ☐ Social
☐ Self-help/Adaptive ☐ Academics ☐ Prenatal Alcohol ☐ Prenatal Drugs ☐ NICU Grad ☐ Feeding Issues ☐ Sleep Issues ☐ Other:

3C. FAMILY CONCERNS AND RISK FACTORS:

☐ None/Unknown ☐ Alcohol ☐ Drugs ☐ Low Parental Education ☐ Teen Parent ☐ Single Parent
☐ Neglect ☐ Abuse ☐ Domestic Violence ☐ Gang Involvement ☐ Caregiver Mental Health ☐ Molestation
☐ CPS history ☐ Divorce ☐ Incarceration ☐ Other Court History: ☐ Other:

3D. PREVIOUS & CURRENT SERVICES:

☐ No Services ☐ Triple P, **Level:** ☐ Head Start/Preschool ☐ SARC/IPP ☐ Speech Therapy
☐ Physical Therapy ☐ Occupational Therapy ☐ Special Ed/IEP ☐ 504 Plan ☐ Early Start Program/IFSP
☐ Mental Health ☐ Home Visitation ☐ Parenting Classes ☐ SSI
☐ FIRST 5 Supports: ☐ Other:

ATTACH: ASQ-3 SUMMARY PAGE AND ASQ: SE SUMMARY PAGE (NOT OLDER THAN 60 DAYS) Fax the referral form and required documents to BHSD CALL CENTER at (408) 938-4536

3E. NOTE SPECIFIC CAREGIVER CONCERNS: *(please explain on additional paper if more room is needed)*

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Referring Person's Name:

<u>Referral Form- Comments, Notes, Additional Information</u>

*ATTACH: ASQ-3 SUMMARY PAGE AND ASQ: SE SUMMARY PAGE (NOT OLDER THAN 60 DAYS) <u>Fax the referral form and required documents to **BHSD** CALL CENTER at (408) 938-4536</u>*