San Mateo County Puente Mental Health Clinic
Consultation and Service Request *

*The Puente Clinic provides mental health services for clients with developmental disabilities. Only clients of Golden Gate Regional Center are eligible for services.

Date _____

From: _____ Phone_____

RE: Client _____ DOB _____/_____/_____

Client address_____ Phone #_____

How long at current address? _____ Name of home _____

SSN _____ - _____ -_____ Primary language_____ Gender (circle) M / F

Ongoing GGRC Case Manager _____ Phone # _____

Is the client conserved? _____ Who is conservator?_____

Conservator phone # _____ Conservator fax # _____

Client's transportation _____ Staff Contact _____

Current Insurance/Benefit Coverage: Is client covered by any of the following? (please circle)

Medi-Cal _____ Medi-Care Private

Insurance Plan Name_____

Current Primary Care MD _____Phone # _____

Current Psychiatrist _____Phone # _____

Current DSM IV Diagnosis: Axis I_____

Axis II: _____

Is client verbal? _____

Please indicate type of services requested:
□ Assessment
□ Medication evaluation
□ Medication management
□ Polypharmacological evaluation
□ Psychiatric/Case Consultation (brief evaluation, not ongoing)
□ Psychotherapy
□ Stabilization for psychiatric disorder

Please Note the Following Priority Criteria for Eligibility: Please check boxes below if client fits any of the following criteria: (If requesting consultation only or one- time medical evaluation only, the following criteria need not be met)

☐ In Agnews and returning to community
☐ Recently returned to the community from locked or delayed egress facility
☐ At-risk for admission to higher level of care
☐ Requires in-home services as clinically determined
☐ Psychiatric Emergency Services contact
☐ Complex diagnostic issues or polypharmacy
☐ Referred by specialty PCP

Is the client currently employed? N Y If yes, place of employment: _____

Staff Day Program Contact Person: _____
(name and phone number)

Is client receiving psychiatric medications? N Y <u>Please list below or attach current list (include dosage and times of administration</u>. When do prescriptions end?

Prescribing MD:_____ **Phone # ( )** _____

Does client have active substance abuse problems? N Y If so, what substances?

Existing Medical Problems:

Current problems/symptoms prompting request for MH services at this time:

Previous Interventions (e. g. medication; behaviorist; therapy):

<u>Description of intervention</u>	<u>Date of Intervention</u>	<u>Outcome</u>

Level of Need: Pleases provide information regarding specific risks (e.g. health and safety, housing, day program/employment) or any acute conditions that are currently impacting this consumer:

Please include the following along with this referral to the Puente Clinic: release of Information forms from GGRC & PCP, most recent IPP and face sheet. <u>Helpful items</u> would also be the annual review, complete admission and discharge reports, medication regimens, social history reports, and reports from reviews and evaluations.

If completed by GGRC Social Worker please have supervisor sign below.

_____ _____

GGRC Supervisor (Print Name) **GGRC Supervisor Signature** **Date**