COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

YOUTH SUBSTANCE USE TREATMENT REFERRAL COVER SHEET

To: Behavioral Health Call Center
BHSDCallCenter@hhs.sccgov.org **From:**

Re: Youth SUTS Outpatient Referral **Total Pages:**

REFERRAL PACKET CHECKLIST

☐ **Cover Sheet**
☐ **Referral Form must be completed by referent**
☐ **Release of Information (ROI) must be signed and dated by youth. Please include date range (item 4 of ROI)**
☐ **Other documents from referent**

Instructions:

1. **Please complete checklist in its entirety.**
2. **Referral will be incomplete and not processed if there is missing information on referral form and if youth has not signed and dated the ROI.**
3. **Referral will NOT be processed without youth's signature, initials, date range and date of signature.**
4. **The purpose of the ROI is to ensure that BHSD Call Center can disclose to the referral source the disposition of the referral, and for the provider to inform you that the referral was received and if contact has been made with the youth.**

For additional information on the purpose of youth consent and ROI, please see language below on 42CFR.

42CFR: Title 42 of the Code of Federal Regulations (CFR) Part 2: Confidentiality of Substance Use Disorder Patient Records (Part 2). Part 2 Programs are federally assisted programs. In general, Part 2 Programs are prohibited from disclosing any information that would identify a person as having or having had a SUD unless that person provides written consent. Part 2 specifies a set of requirements for consent forms, including but not limited to the name of the patient, the names of individuals/entities that are permitted to disclose or receive patient identifying information, the amount and kind of the information being disclosed, and the purpose of the disclosure.

Substance Use Treatment Network of Providers:

- Alexian Health Center Clinic, BHSD, Children, Youth and Family's Division
- Asian American Recovery Services, Healthright 360
- Starlight Community Services

For additional information about Youth SUTS Program, visit
Youth Substance Use Treatment Services - Behavioral Health Services - County of Santa Clara (sccgov.org)

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YOUTH SUBSTANCE USE TREATMENT REFERRAL FORM

Behavioral Health Call Center: Phone: (800) 704-0900**, Email:** BHSDCallCenter@hhs.sccgov.org

Section 1: Referral Source Information

Referring Person Name:	**Referring Person's Phone:**	**Referring Person's Email:**
Today's Date:	**Referring Agency and Program Name:**	

Section 2: Youth's Information

Avatar ID:

Youth's Name:	**DOB:**	**Age:**
Gender:	**Ethnicity:**	**Primary Language:**
Youth's Phone Contact Information:		**Best time to call youth:**
Address:		**Home Type:**
Health Insurance Type:	**Medi-cal ID:**	**SSN:**
Is youth pregnant: ◯ **Yes** ◯ **No** ◯ **n/a**		**Is youth a parent:** ◯ **Yes** ◯ **No** ◯ **n/a**
School Name:	**Grade:**	**Attendance concerns:** ☐ **Yes** ☐ **No**

Reason for Referral *(please indicate current substance use concerns, frequency and known last use)*:

Is youth taking psychiatric medication? ☐ **Yes** ☐ **No, If yes, list names:**
Is youth taking any Medication Assisted Treatment, such as, Buprenorphine or Suboxone: ☐ **Yes** ☐ **No**

Preferred services: **Means of transportation for youth:**

Section 3: Adult Support Person Information and/or Parent/Legal Guardian/Caregiver Information

Support Person Name: **Relationship to youth:**
Does youth give consent to contact this person: ☐ **Yes** ☐ **No**
Does adult live with youth: ☐ **Yes** ☐ **No** **Contact Phone Number:**
Primary Language:

Parent/Guardian/Caregiver Name: **Relationship to youth:**
Does youth give consent to contact this person: ☐ **Yes** ☐ **No**
Does adult live with youth: ☐ **Yes** ☐ **No** **Contact Phone Number:**
Primary Language:

Parent/Guardian/Caregiver related Information:

☐ Parental substance use
☐ Parental or family member loss
☐ Low parental involvement
☐ Estrangement from family
☐ Domestic Violence
☐ Pre-natal substance use exposure
☐ Single Parent
☐ Medical and Health Issues
☐ Housing instability
☐ CPS History

Additional Comments:

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Section 4: Care Coordination Information *(please indicate all known contacts)*		
Service Type	**Name and Role**	**Contact Phone & Email** ***if not referral source***
☐ Pediatrician/MD		
☐ Social Worker (DFCS)		
☐ Deputy Probation Officer (DPO)		
☐ Mental Health Clinician or Team Member *(please indicate if there is a known team or program)*		
☐ Psychiatrist		
☐ School Personnel (ie-School Social Worker, Counselor, etc)		
☐ SUTS Residential		
☐ Other		

Section 5: Complete if referent is BHSD, DFCS or Probation

Is youth Dually Involved Youth: ☐Yes ☐No
Please ensure you list DFCS SW and DPO in section 4. If youth is connected to DIY Advocate with BHSD, please also list contact information in Section 4.

Is youth identified as CSEC: ☐Yes ☐No
If yes, please list additional CSEC Advocate, or team members youth is connected to in Section 4.

Please list all BHSD Program or Teams youth is currently participating in:
(ie-DFCS or JPD Wraparound, Katie A, FSP, Outpatient, Juvenile Justice Program)

JPD only:

1. **Is youth currently in-custody? ☐Yes ☐No**

If youth is in-custody, indicate in-custody facility: Other
Expected release date:

Indicate any future MDT or CFTs meetings if known:

Section 6: Complete if referent is SUTS Residential

Admission date to program:

Expected discharge date:

Current medication if applicable:

Requesting SUTS Program and Provider:

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1 Patient Name: _____
Date of Birth: _____
ID or Medical Record # _____
Address: _____
_____
Tel: _____

2 **AUTHORIZATION:** I give permission to Behavioral Health Services Department (BHSD) to use and release to Recipient Name: See Attachment B _____
Address: _____
Phone: _____ Fax: _____

3 **PURPOSE:** The health information disclosed may only be used for the following purpose(s): _____
Screening, referral, coordination, and connection to youth treatment services.
_____

4 **INFORMATION TO BE RELEASED** _____

Date From: To:

A. ☐ **Medical Record** ☐All health information (e.g. diagnosis, test results, treatment); OR
☐ Images and/or Films ☐ Reports ☐ Billing ☐ Dental

B. ☐ **HIV/AIDS Test Results** (A separate authorization is required for each disclosure.) **Initial**: ___

C. ☒ **Drug & Alcohol Treatment** (e.g. Referral status and coordination of services) **Initial**:___

D. ☒ **Mental Health** (e.g. diagnosis, test results, treatment, billing) **Initial**:___

E. ☐ **Other** _____ **Initial**:___

5 **DELIVERY PREFERENCE:**
☐ Mail ☐ Pick up ☐ Other _____

6 **DELIVERY FORMAT:**
☐ CD ☐ Film ☐ Paper ☐ Other _____

7 **DURATION:** This authorization is valid immediately and will be valid until _____ (*give date*).
If I do not write in a date, it will expire twelve months from the date it was signed.

8 **CANCELLATION**: I understand that I have a right to cancel this authorization any time. A cancellation (1) must be in writing, (2) sent or given to the Health Information Management Department and 3) is effective when it is received by the department. A cancellation will not apply to actions already taken by CSCHS under this authorization or if the authorization was required for getting insurance coverage and the insurer has a legal right to contest a claim. Verbal cancellation will be accepted for behavioral health medical record pursuant to WIC Section 5328. Call: 408-885-5770.

9 **CONDITIONS:** I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on my giving or refusing to give this authorization except if my treatment is related to research, or if health care services are given to me only for creating protected health information for release to a third party. I also understand that I may refuse to sign this authorization.
A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

10 **REDISCLOSURE:** Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA), although information protected by 42 CFR Part 2 continues to be subject to that protection. In addition, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

11 _____ _____ _____ _____
Patient/Patient's Representative Name Patient/Patient's Representative Signature Relationship Date

COUNTY OF SANTA CLARA
Behavioral Health Services

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____
Date of Birth: _____
ID or Medical Record # _____
Address: _____
_____
Tel: _____

Attachment B: List of recipients who may receive my information if necessary.

Recipients:

Referring Party for referral status updates only: (Check one)

- ◯ Juvenile Probation
- ◯ Department of Family and Children Services
- ◯ Primary Care Provider
- ◯ School (List name): _____

- AARS/Healthright 360
- Starlight Community Services
- Alexian Health Center Clinic, BHSD, Children, Youth and Family's Division
- Evolve Adolescent Behavioral Health

☐ Other Behavioral Health Treatment Provider

_____

☐ My Parent/s or guardian/s

Name(s): _____

Phone number(s): _____

Address(es): _____

_____

_____