SANTA CLARA COUNTY
Behavioral Health Services

# Forensic, Diversion, and Reintegration Division Referral Form

Please fill out as many fields as possible. Email form to: CJSReferrals@hhs.sccgov.org

| **Referral Source** | | | | | |
|---|---|---|---|---|---|
| Referral Date | Click or tap to enter a date. | | Referral Source | Choose an item.<br>If other: Click or tap here to enter text. | |
| Staff Name and Title | Click or tap here to enter text. | | | | |
| Staff Phone Number | Click or tap here to enter text. | | | | |
| **Client Information** | | | | | |
| Client Legal Name | Click or tap here to enter text. | | | | |
| Client Goes By Name | Click or tap here to enter text. | | | | |
| Client Pronouns | ☐She/her/hers<br>☐He/him/his<br>☐They/them/theirs | ☐Another pronoun set: Click or tap here to enter text.<br>☐Name only<br>☐Prefer not to answer | | | |
| Gender Identity | Choose an item.<br>If another gender identity: Click or tap here to enter text. | | | | |
| Preferred Language | Choose an item. | | | | |
| Private Insurance | Choose an item. | | | | |
| Client Phone Number | Click or tap here to enter text. | | | | |
| Date of Birth | Click or tap to enter a date. | | SSN | Click or tap here to enter text. | |
| MRN | Click or tap here to enter text. | | Unicare Numbers | Click or tap here to enter text. | |
| Judge | Click or tap here to enter text. | | Dept. | Click or tap here to enter text. | Next Court Date: Click or tap to enter a date. |
| Any of the following: | ☐Sex Offender Registrant<br>☐Fire Starting Behavior<br>☐Recent Assaultive Behavior | | | | |
| If client has conservatorship, please list conservator name and phone number. | Click or tap here to enter text. | | | | |
| If client has a pretrial, parole, or probation officer, please list name and phone number of officer. | Click or tap here to enter text. | | | | |
| If client has Child Dependency Court Social Worker, please list name and phone number. | Click or tap here to enter text. | | | | |
| Custody Housing (Location): Main Jail or Elmwood Correctional Facility (if client is currently in custody) | Click or tap here to enter text. | | | | |
| Custody Release Date (if client is currently in custody) | Click or tap to enter a date. | | | | |

| **Brief Jail Mental Health Screening (Please ask your client the following information)** | |
|---|---|
| 1. Do you currently believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head? | Choose an item. |
| 2. Do you currently feel that other people know your thoughts and can read your mind? | Choose an item. |
| 3. Have you currently lost or gained as much as two pounds a week for several weeks without even trying? | Choose an item. |
| 4. Have you or your family or friends noticed that you are currently much more active than you usually are? | Choose an item. |
| 5. Do you currently feel like you have to talk or move more slowly than you usually do? | Choose an item. |
| 6. Have there currently been a few weeks when you felt like you were useless or sinful? | Choose an item. |
| 7. Are you currently taking any medication prescribed for you by a physician for any emotional or mental health problems? | Choose an item. |
| 8. Have you ever been in a hospital for emotional or mental health problems? | Choose an item. |

**If requesting substance use treatment, please provide a brief description of recent substance use. Please indicate if client needs referral to the STEP program.**

Click or tap here to enter text.

| **Disposition - ONLY for BHSD CJS Team to fill out** | |
|---|---|
| Accepted | Choose an item. |
| Agency | Choose an item.<br>If other agency: Click or tap here to enter text. |