



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
- ❖ Asian American for Community Involvement (AACI)
- ❖ Starlight

For additional information about Youth SUTS Program, visit

[Youth Substance Use Treatment Services - Behavioral Health Services - County of Santa Clara \(sccgov.org\)](http://www.sccgov.org)



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: Choose an item.	Ethnicity:	Primary Language: Choose an item.
Youth's Phone Contact Information:	Best time to call youth:	
Address:	Home Type: Choose an item.	
Health Insurance Type: Choose an item.	Medi-cal ID:	SSN:
Is youth pregnant: Yes No n/a	Is youth a parent: Yes No n/a	
School Name:	Grade:	Attendance concerns: <input type="checkbox"/> Yes <input type="checkbox"/> 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: Choose an item.

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: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does adult live with youth: <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact Phone Number:
Primary Language: Choose an item.	
Parent/Guardian/Caregiver Name:	Relationship to youth:
Does youth give consent to contact this person: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does adult live with youth: <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact Phone Number:
Primary Language: Choose an item.	

Parent/Guardian/Caregiver related Information:

- | | |
|---------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Parental substance use | <input type="checkbox"/> Pre-natal substance use exposure |
| <input type="checkbox"/> Parental or family member loss | <input type="checkbox"/> Single Parent |
| <input type="checkbox"/> Low parental involvement | <input type="checkbox"/> Medical and Health Issues |
| <input type="checkbox"/> Estrangement from family | <input type="checkbox"/> Housing instability |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> CPS History |

Additional Comments:



Section 4: Care Coordination Information *(please indicate all known contacts)*

Service Type	Name and Role	Contact Phone & Email <i>if not referral source</i>
<input type="checkbox"/> Pediatrician/MD		
<input type="checkbox"/> Social Worker (DFCS)		
<input type="checkbox"/> Deputy Probation Officer (DPO)		
<input type="checkbox"/> Mental Health Clinician or Team Member <i>(please indicate if there is a known team or program)</i>		
<input type="checkbox"/> Psychiatrist		
<input type="checkbox"/> School Personnel <i>(ie-School Social Worker, Counselor, etc)</i>		
<input type="checkbox"/> SUTS Residential		
<input type="checkbox"/> 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:

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:



COUNTY OF SANTA CLARA
Behavioral Health Services

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): _____

4 INFORMATION TO BE RELEASED _____

Date From: _____ To: _____

A. <input type="checkbox"/> Medical Record	<input type="checkbox"/> All health information (e.g. diagnosis, test results, treatment); OR <input type="checkbox"/> Images and/or Films <input type="checkbox"/> Reports <input type="checkbox"/> Billing <input type="checkbox"/> Dental	Initial: _____
B. <input type="checkbox"/> HIV/AIDS Test Results (A separate authorization is required for each disclosure.)		Initial: _____
C. <input type="checkbox"/> Drug & Alcohol Treatment (e.g. Referral status and coordination of services)		Initial: _____
D. <input type="checkbox"/> Mental Health (e.g. diagnosis, test results, treatment, billing)		Initial: _____
E. <input type="checkbox"/> 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): _____

- Asian Americans for Community Involvement (AACI)
- Advent Group Ministries
- AARS/Healthright 360
- Starlight Community Services
- The Camp

Other Behavioral Health Treatment Provider

My Parent/s or guardian/s

Name(s): _____

Phone number(s): _____

Address(es): _____

