SANCTUARY CENTERS
OF SANTA BARBARA
Advancing Mental Health Through Treatment and Education

*Instructions for Referral to **Residential Treatment** (Sanctuary House):*

1. Physician, Psychiatrist, or Licensed Therapist must complete the **Referral Form** on the following pages.
2. Applicant or representative must complete the **Preplacement Appraisal Form**: http://www.sanctuarycenters.org/pdfs/forms/preplacement-appraisal-form.pdf
3. Submit the **Referral Form** and the **Preplacement Appraisal Form** together to:

   Attn: Clinical Director
   Sanctuary Centers of Santa Barbara
   PO Box 551, Santa Barbara, CA 93102

   Telephone: 805.569.2785
   Fax: 805.563.1977

*Instructions for Referral to **Outpatient Treatment** (Arlington Day Treatment Center):*

1. Physician, Psychiatrist, or Licensed Therapist must complete the **Referral Form** on the following pages.
2. Submit the **Referral Form** to:

   Attn: Arlington Day Treatment Program Director
   Sanctuary Centers of Santa Barbara
   PO Box 551, Santa Barbara, CA 93102

   Telephone: 805.569.2785
   Fax: 805.564.3448

Important: For privacy purposes, save this PDF file to your computer first and then open and edit the file that you have saved.

SANCTUARY CENTERS OF SANTA BARBARA

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REFERRAL FORM

(= Required Information)*

***Referral for:** ☐ Residential Treatment ☐ Outpatient Treatment

*Referring Agency: _____ *Phone: _____

*Person completing this form: _____ *Date: _____

Authorization: ***"I authorize the transmission of information concerning my history, care and treatment to authorized personnel at Sanctuary Centers of Santa Barbara. This authorization is granted on condition that due care be exercised at all times with respect to my rights to privacy and confidentiality. This authorization is not a waiver of any privilege conferred on me by law or regulation."***

***Signed:** _____ ***Date:** _____

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*Client Name: _____ *Phone: _____

*Address: _____

*Date of Birth: _____ *Age: _____ *Gender: [Choose One]

*Marital Status: [Choose One] *Race: [Choose One] *Ethnicity: [Choose One]

Religion: _____ *Social Security #: _____

Medi-Cal #: _____ Other Health Insurance: _____

*Source of Income: ☐ SSI: $_____ ☐ Family: $_____

☐ Other: $_____, Description: _____

*Income Approved? ☐ Yes ☐ No

Conservatorship: ☐ Finances ☐ Personal Expiration Date: _____

Conservator Name: _____ Phone: _____

Parent/Guardian Name(s): _____

Marital Status: [Choose One] Phone Number(s): _____

CLINICAL INFORMATION:

*Diagnostic Impression:

A) _____ _____
DSM-5 Code DSM-5 Description

B) _____ _____
DSM-5 Code DSM-5 Description

C) _____ _____
DSM-5 Code DSM-5 Description

D) _____ _____
DSM-5 Code DSM-5 Description

E) _____ _____
DSM-5 Code DSM-5 Description

F) _____ _____
DSM-5 Code DSM-5 Description

G) _____ _____
DSM-5 Code DSM-5 Description

I. PRESENTING PROBLEMS:

*A. Current difficulties and brief description of onset of emotional problems. Why is this referral being made?

*B. Mental Status: Appearance, affect, orientation, mood, preoccupation, thought content and process.

*C. Psycho-social Stressors: Assess factors that contribute to current status.

*D. Family History: Assess relationship, past and present, with family.

*E. Social History: Assess relationship, past and present, with friends, other social agencies, etc. Include any information available on education history, work history.

*F. Current Living Situation (not hospital):

*G. Drug and/or Alcohol Abuse (past or present):

*H. Suicide Attempts and/or Ideation (include means of attempt, past or present):

CRIMINAL HISTORY

*I. Previous engagement in violent or other anti-social activity:

*Please assess current potential for violence:

*J. Current Legal Status (probation, court date(s), charges pending):

II. TREATMENT HISTORY:

*A. State or Other Psychiatric Hospitalizations: Include locations, dates and durations, if information available. Include drug treatment history. Describe precipitant factors.

*B. Therapy contacts: Past and present, in addition to referring agency. Include outpatient programs.

*C. Physician Information:

Last Name: _____ First Name: _____

Address: _____ Phone: _____

*D. Psychiatrist Information:

Last Name: _____ First Name: _____

Address: _____ Phone: _____

IV. MEDICATION EVALUATION/MEDICAL CONCERNS:

*A. Medication: Type, dosage, length of time on these medications.

*B. Drug Allergies:

*C. Other Allergies:

*D. Describe General Physical Health and Medical Concerns:

*E. Dietary Restrictions:

*F. Date of last Physical Examination: _____ *Results: _____

*G. Medical Devices (e.g. contact lenses, IUD, pacemaker, etc.):

*H. Seizure History & Activity in the Past Year:

V. TREATMENT PLANNING:

*A. Describe treatment plan developed by your agency or which you would consider appropriate for this client:

*B. What areas would you consider to be potential problems for this client in a group living situation (cooking, cleaning, use of free time, etc.)?

Signed by: _____ Date: _____

FOR ADDITIONAL COMMENTS, PLEASE USE ADDITIONAL SHEETS

PLEASE ATTACH ALL APPROPRIATE DISCHARGE MATERIAL

FOR REFERRALS TO RESIDENTIAL TREATMENT, PLEASE ALSO COMPLETE THE *PREPLACEMENT APPRAISAL FORM*:
http://www.sanctuarycenters.org/forms.html