Referral Form- ADAPT

For PHN Referrals:
Referral Date: _____

Referral Source: Region_____
MCH ☐
NFP ☐
SIDS ☐
Name of Nurse: _____

For Hospital and Other Referrals:

Referral Source:_____
☐ Hospital ☐ Birthing Center ☐ Other
Name of Referring Individual: _____

MCH/NFP Referral Status:
☐ Pending ☐ Referral not expected at this time
☐ Complete

Client Information *(*Fields marked with an asterisk are required)*

*Client Name: _____ *Address: _____

*Insurance: _____ *DOB: _____ *Phone Number: _____

*Medi-Cal Number: _____ *Social Security number:_____

What is the best way to contact client? _____ Who lives in residence? _____

Child information: *Expected due date: _____ *Date of Birth: _____

Primary Language: _____ Ethnicity: _____ Other Agencies/Organizations Involved:

Clinical Information

Is the person interested in mental health services? Yes☐ No☐ Current Safety Plan: Yes☐ No☐ Date: _____

Substance Use: Yes☐ No☐ Substances used: _____ Date of Last use: _____

Medical Problems (including mental health): _____

Medications (currently taking and meds prescribed but not taking): _____

Presenting Peripartum Symptoms or Concerns (*Including, but not limited to, pregnancy status, date of onset of symptoms, barriers, challenges, past/current mental/physical health diagnosis, any medication prescribed, safety concerns, any other relevant information)*

PHQ- 9 score: _____ Date Administered: _____ Other Assessments conducted? _____

Signature of Referring Individual: _____ Date: _____

Phone:_____ Email:_____

Please submit referrals to adaptreferrals@vistahill.org via secure email

ADAPT USE: Family Number:_____ Participant Number:_____

ACE Score :_____ Date of administration: _____

Client Enrolled Yes☐ No☐ Date: _____If no, why not? _____
Level of care recommended? Level 1☐ Level 2☐

Level of care assigned? Level 1☐Level 2☐ Therapist/Peer Partner Assigned: _____

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