VISTA HILL

CCYP
Center for Child and Youth Psychiatry

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO LIVEWELLSD.ORG

Program Referral Request Form

Thank you for your interest in receiving services through the Vista Hill Center for Child and Youth Psychiatry (CCYP). ***CCYP is a System of Care resource available to youth and families who meet specific eligibility criteria****. Please take a moment to let us know a little about the services that are needed. A member of the CCYP team will reach out to you to acknowledge receipt of the referral and review any questions. We look forward to working with you.*

REFERRAL SOURCE

Referring Agency:_____ Contact:_____

Phone #:_____ Email:_____ Date:_____

☐ A current Behavioral Health Assessment and ☐Psychiatric Evaluation is available in the County Health Record

ELIGIBILE REFERRAL TYPE AND REQUESTED SERVICE

☐ **System of Care Medication Management Clinic**. Available to youth who have successfully completed a mental health treatment episode, are stable, without recent psychiatric hospitalization, and do not require mental health therapy.
Treatment Episode dates: Intake date_____ Planned Discharge date_____.
Has the youth experienced acute suicidal ideation in the past month? ☐ *Yes* ☐*No*
Has the youth been psychiatrically hospitalized in the last 90 days? ☐ *Yes* ☐*No*

☐ **Ancillary Psychiatry Services Support**. Available to youth currently in treatment in the San Diego System of Care and whose program does not currently have psychiatry. Contracting Officer Representative program approval required.
Please specify if ☐ Cajon Valley School District Partnership

☐ **Short Term Residential Treatment**. Available to youth residing in partnering STRTP programs pre-approved by the Contracting Officer Representative.

☐ **Medication Assisted Treatment**. Available to youth enrolled in Substance use treatment programs who could also benefit from psychiatric medication management.

☐ **Other Request**: ☐JV220 Second Opinion ☐ Long- Acting injectables

_____

CLIENT INFORMATION

Name:_____ DOB:_____ Sex assigned at birth: ☐Male ☐Female ☐Other

Address:_____Phone:_____

Preferred Language:_____ Preferred Name:_____ Pronouns:_____

With whom does the client reside:_____

PARENT / CARGIVER INFORMATION

Name:_____ Relationship:_____ Phone:_____

Address: ☐Same as client or _____

☐Able to provide Legal Consent. Preferred Language: _____ email:_____

Name:_____ Relationship:_____ Phone:_____

Address: ☐Same as client or _____

☐Able to provide Legal Consent Preferred Language: _____ email:_____

CLIENT INSURANCE

MediCal #_____ Other Health Insurance_____ Uninsured_____

MEDICAL HOME

Primary Care Provider:_____ PCP Clinic_____ Phone:_____

Relevant medical issues_____

_____