



**Older Adults 60+  
Field Capable Clinical Services  
Referral Form**

**Referral Information**

Date:.....

Last Name:..... First Name: .....

DOB: ..... Race/Ethnicity:..... Gender:       M       F

Address: ..... City: ..... Zip: .....

Phone: (    ) ..... Current living situation: .....

Insurance:

(    ) Medi-Cal      (    ) Medi-Care      (    ) V.A.      (    ) Private      (    ) None

PRIMARY CONTACT: ..... RELATIONSHIP: .....

PREFERRED LANGUAGE ..... PHONE: (    ) .....

CONSERVATOR:     YES       NO    IF YES, WHOM? : .....

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**REFERRAL SOURCE**

Agency: ..... Contact Person: .....

Phone: (    ) ..... Fax: (    ) ..... Email: .....

Individual currently receiving services, either within or outside your agency?:     YES       NO

If yes, please identify:.....

**Other Agency Involvement?**    (    ) HMO    (    ) Adult Protective Services    (    ) GR/DPSS    (    ) Office of Aging

Has individual been referred to any other programs, please identify: .....

**NOTE:** This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPPA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

**ELIGIBILITY GUIDELINES INFORMATION**

**A. Individual is age 60 or older?** \_\_\_ Yes \_\_\_ No (If individual is not 60+, please specify age: \_\_\_)

**B. Check one of the following:**

- Individual has a serious or persistent mental illness for which they are currently being treated Or who has previously been treated.
- Individual has mental health symptoms that are not severe or persistent but is accompanied by a functional impairment in activities of daily living or instrumental activities of daily living.
- Individual is at risk of losing or not attaining stable or safe living arrangements, risk of losing Or inability to access needed services (including caregiver services), risk or losing independence due to mental health symptoms.

Provide details for any checked items:

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**C. CHECK ONE OF THE FOLLOWING:**

- Other senior service agencies have been contacted/ indentified, but are not available to Provide appropriate/ relevant services to this individual
- Individual cannot otherwise be appropriately served by another senior service agency

Provide details for any checked items:

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**SPECIFIC REASON FOR REFERRAL**

Referrals with Dementia are not able to benefit from this program and are better referred to their MD or a Neurologist

**A. Mental Health Symptoms:**

Please check all that apply:

- Depressed Mood
- Suicidal thought/comments
- Anxious mood
- Suspicious of others
- Aggressive thoughts/behavior
- Strange/unusual behavior
- Inappropriate sexual acts
- Recent or past traumatic event

Please explain any checked items:

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**SPECIFIC REASON FOR REFERRAL**  
**CONTINUED**

**B. Other Related / Relevant Issues of Concern:**

Please check all that apply:

- |   |  |
|---|--|
| <input type="radio"/> Isolated / Homebound      | <input type="radio"/> History / risk of abuse or neglect |
| <input type="radio"/> Substance / Alcohol Abuse | <input type="radio"/> Medical problems / conditions      |

Please explain any checked items:

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**You may direct any questions or fax this referral form to:**

**Tri-City Mental Health Center  
Field- Capable Clinical Services**

Attention: Toshi Kuramatsu LCSW  
Fax: (909) 865-9281  
Phone: (909) 623-6131  
Email: [tkuramatsu@tricitymhs.org](mailto:tkuramatsu@tricitymhs.org)

\* Additional referral forms can be downloaded at [tricitymhs.org](http://tricitymhs.org)

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# DISPOSITION

To be completed by FCCS Agency

Date received: .....

Authorized for Enrollment:

Program Supervisor: \_\_\_\_\_ Phone: \_\_\_\_\_

Assigned Clinician: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_

Authorizing Representative: \_\_\_\_\_ Date: \_\_\_\_\_

FCCS Agency Notified Date: \_\_\_\_\_

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Not authorized for Enrollment (Explain reasons for decision and plan for linkage to other services):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Individual does not agree to services (explain reason for decision and plan for linkages)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FCCS Agency Representative: \_\_\_\_\_ Date: \_\_\_\_\_

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