Hillsides
CREATING LASTING CHANGE

Bienvenidos
an affiliate of Hillsides

☐ **Echo Park**
1910 Sunset Blvd. #650
Los Angeles, CA 90026

☐ **East Los Angeles**
5400 E. Olympic Blvd.
Los Angeles CA 90022

☐ **South Pasadena**
149 Pasadena Ave. #A
S. Pasadena, CA 91030

☐ **Baldwin Park**
13001 Ramona Blvd. #A
Irwindale, CA 91706

☐ **YMO**
465 E. Orange Grove Blvd. #140
Pasadena CA 91104

Please email us at:
intake@hillsides.org

Mental Health Services Referral Form

I. Client's Identifying Information: ** Use black ink*

Date: ____________

Name: ______________________ (M.I.): ____ Sex: ☐ M ☐ F ☐ Other DMHID#: ________

D.O.B: __________ Age: _____ Race/Ethnicity: ________ Grade: ___ Primary Language: ________

Soc. Sec.#: ______________ Medi-Cal ☐ Y ☐ N If yes, Medi-Cal #: ______________

Biological Mother's Name: ________________ Biological Father's Name: ________________

II. Primary Caregiver Information of Client:

Client currently lives with: ☐ Mother ☐ Father ☐ Guardian ☐ Foster Parent ☐ Self ☐ Other (specify): ____________

Name: ______________________ Primary Language: ______________________

Phone: ______________ Alternate Phone: ______________ Okay to leave message? ☐ Y ☐ N

Address: ______________ Apt: ______ City: ______________ Zip: ______

Referred by: ______________ Phone:#: ______________ Email: ______________

Experiencing the Following:

☐ Suicidal: Ideations/ Hx/ Intent/ Self Harm	☐ Difficulties at School	☐ Impulsive/ Hyperactive/ Inattentive
☐ Homicidal: Ideation/ Hx/ Intent	☐ Disruptive Behaviors	☐ Isolation/ Withdrawal
☐ Hx of Abuse/ Trauma/ DV/ Bullying	☐ Irritability	☐ Flashbacks
☐ Aggression/ Destruction of Property	☐ Difficulty Concentrating	☐ Fearfulness
☐ Sadness/ Depressed/ Cries Often	☐ Temper Tantrum/ Mood Changes	☐ Nightmares
☐ Hallucinations (Visual, Auditory, etc)	☐ Defiance/ Non-compliant	☐ Anxious

Parent/Caregiver/ Client would like therapy to address the following concerns:

____
____
____
____
____
____
____

Who holds custody of client? ☐ Biological Mother ☐ Biological Father ☐ Other: ______________

Has the client had any traumatic experiences: ☐ Y ☐ N If yes: ______________

History of Domestic Violence: ☐ Y ☐ N If yes: ______________

DCFS Involvement: ☐ Y ☐ N If yes: ______________

Prior Episodes/Psychiatric hospitalizations/Psychiatric Hx: ☐ Y ☐ N If yes: ______________

Medical Issues (ex: asthma, diabetes, etc.) ☐ Y ☐ N If yes: ______________

Confidential Patient Information
See Calif. W & I Code 5328