Behavioral Health Request for Specialty Mental Health Services

***All fields must be completed. Incomplete referrals will be returned**

Submit completed referrals to BCDBH Quality Management at dbhqm@buttecounty.net

Child/Youth Identifying Information

Child/Youth Name:		Date of Referral:	
Child/Youth Address:		City/Zip:	
Phone:	DOB:	Gender:	
Medi-Cal Card#:		Social Security #:	
Parent/Guardian/Social Worker Name:		Phone:	

Relationship to Child/Youth: ◯ Legal Parent ◯ Legal Guardian ◯ Caretaker ◯ Social Services

Primary Language Spoken at Home:

Referring School/Agency

Referring School/Agency:		Referring Party:	
Phone Number:		Referring Party Email:	

Active IEP: ◯ Yes ◯ No

Is youth currently receiving mental health services? ◯ Yes ◯ No

If yes, please specify:

Primary Problem Area: ◯ Home ◯ School ◯ Juvenile Justice ◯ Other

Behaviors and/or Problems Presented:

Preferred Service Location: ◯ School Campus ◯ No Preference ◯ Clinic/Counseling Center ◯ Field Based

Quality Management Use Only

Butte County Medi-Cal: ◯ Yes ◯ No	OOC Medi-Cal: ◯ Yes ◯ No
Open to Other Services? ◯ Yes ◯ No	

County:		Date Received:	
Aid Code:		Sent to Provider:	
Client #:		Services are at:	