San Bernardino County of San Bernardino
Department of Behavioral Health

Interdisciplinary Care Team (ICT) Referral Form

Referring Party Information

Referring Party:	Agency: ☐IEHP ☐Kaiser ☐Molina ☐SBDBH	Clinician Name:	Clinic:	Phone:

Member Information

Member Name:	MHP ID:	SSN:	DOB:	Age:	Gender:

Address:	City:	State:	Zip:

Phone:	Guardian Name:	Guardian Phone:

Living Arrangements: ☐Private Home ☐Board & Care ☐Relative Placement ☐Homeless

Physical Limitations: ☐Hearing Impaired ☐ Visually Impaired ☐Wheelchair Dependent ☐ None ☐ Other

Patient Signed Release: ☐Yes ☐No (If No, this information will NOT be forwarded to the PCP)

Service Requested: ☐Physical Health ☐Mental Health ☐ Substance Abuse Treatment ☐Other

Current Treatment: ☐ None ☐ PCP ☐Health Plan BH Provider ☐ Private, cash-pay provider
☐ County Provider ☐County Clinic ☐ Other: (fill in)

Behavior Problems and Symptoms/Diagnosis; Impairments to Daily Living; Referral Justification:

Clinician agrees with Referral: ☐Yes ☐No

Member agrees with Referral: ☐Yes ☐No

Psychiatrist recommends for continued treatment:
☐Refer back to PCP to manage psychotropic medications
☐Refer to Psychiatrist to manage psychotropic medications

☐**Meets Specialty Mental Health**
☐**Does not meet Specialty Mental Health**

Current Medications/Instructions:

Quantity	Days Supplied	Date Filled

☐ **Medication running out in days**
☐ **Out of Medication**

Safety Risk Assessment

Condition	None/N/A	Mild	Moderate	Severe
Suicidal				
Homicidal				
Non-Suicidal Self-Injury				

Condition	Yes	No
Gravely Disabled		
History of Running Away		

Condition	None	Within last 30 days	Within last 90 days	Within last year
Hospitalizations				

Behavioral/Mental Health Services Requested:

☐ Individual Therapy ☐ Medication Evaluation ☐ Medication Management ☐ Substance Abuse Treatment ☐ Other:

Member/Client Provider Choice:

Signature and Date

Signature: **Date:**