Department of Mental Health
Service Area 2 - SB 82 Mobile Triage Team Referral

Complete all known information

Date: _____

Referred By: _____ **Phone Number:** _____
Name/Organization

Individual's Name / AKA: _____ **Phone Number:** _____

Location/Address: _____

DMH IS/IBHIS #: _____ **Gender:** ☐M ☐F ☐Other

DOB/Age: _____ **Eye Color:** _____ **Hair Color:** _____ **HT:** _____ **WT:** _____

Race/Ethnicity: _____ **Primary Language:** _____
(if other than English)

Length of Homelessness _____

Emergency Contact Information: (Name / Relationship / Number / Address)

_____

SSN: _____ **Benefits:** ☐Medi-Cal ☐Medicare ☐Private ☐VA/Tricare ☐SSI/SSDI ☐None **U.S. Citizen:** ☐Yes ☐No **Documented:** ☐Yes ☐No

Reason for Referral: (Check all that Apply)

☐Homeless ☐Mentally Ill ☐Substance Abuse ☐High Risk Behavior
☐Medical Problems ☐No Benefits ☐Linkage to Mental Health Services
☐Veteran Other: _____

Currently Enrolled in Mental Health Services: ☐Yes ☐No **Describe:** _____

Describe other pertinent history of medical problems, mental illness, arrests/incarcerations, self-harm/violent behaviors

Office Use Only

Practitioner: _____ **Date Assigned:** _____

☐SRL ☐Access Database # _____ Entered by: _____

Disposition / Linkage: _____