Behavioral Health Request For Specialty Mental Health Services

Submit to QM

All fields must be completed. Incomplete referrals will be returned.
Submit completed referrals to BCDBH Quality Management at: **DBHQM@buttecounty.net**

Request Date:

Client Name (Last, First MI): Gender: Primary Language:

Medi-Cal Card # (required): Social Security # (required):

Address (street): Address (city): DOB:

Parent/Guardian/Social Worker Name: Phone Number:

Relationship to Youth: ☐ Legal Parent ☐ Legal Guardian ☐ Caregiver ☐ Social Services

Primary Language Spoken at Home:

Requesting Agency/School: Requesting Party:

Requesting Party Phone Number: Requesting 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/Problems Presented or Special Considerations:

Preferred Service Location (Please check only one): ☐ On School Campus ☐ Clinic/Counseling Center ☐ No Preference

For Quality Management Department Use Only

Butte Co. Medi-Cal ☐ Yes ☐ No OOC Medi-Cal ☐ Yes ☐ No County: Aid Code:

Open to any other MH services? ☐ Yes ☐ No Provider: Service: RFS Approved:

Client Number: Assigned To: