CARE COURT
Consultation & Referral

7001-A East Parkway Sacramento, CA 95823
Email: dhs-bhs-care_court@saccounty.gov | Phone 916-875-9668

All sections of referral must be complete.

Please include any medical documentation that may help the participant.

Client Information	**Date of Birth:**	**PAT ID:**
First Name:	**Middle Name:**	**Last Name(s):**
Street address OR living situation:		
Environmental Risks Known (dog/gates etc.):		
Cell Phone #:	**Other phone #:**	**Email Address:**
Preferred language(s):	**Spoken:** ☐ English ☐ Spanish ☐ Other:_____	**Written materials:** ☐ English ☐ Spanish ☐ Other: _____
Consent for Referral:	☐ Verbal Client Consent *(i.e. via phone)*	☐ In person *(have client sign here)*
Consent for Follow-up with referring party/agency:	☐ Verbal Client Consent *(i.e. via phone)*	☐ *In person (have client sign here)*

Referring agency use ONLY		
Referring Agency:	**Date Referral Submitted:**	
		☐ **Consultation** ☐ **Referral**
Court ☐ **Inpatient Hospital** ☐ **BHS** ☐		
Person sending Request:	**Direct phone number:**	**Email:**

REQUIRED

CARE Court Criteria: Please complete <u>all that apply</u> regarding the potential participant's eligibility for CARE Court. The participant must meet all the below criteria to be eligible for CARE:

- ☐ 18 years or older
- ☐ Experiencing severe mental illness with a diagnosis in the schizophrenia spectrum and other psychotic disorder class. Current Diagnosis, if known:
- ☐ Not clinically stabilized in on-going voluntary treatment
- ☐ Meets **ONE** of the following:
  - ☐ The person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating
  - ☐ The person needs services and support in order to prevent a relapse of deterioration that would be likely to result in grave disability or serious danger to self or others, as defined in section 5150.
- ☐ CARE is the least restrictive alternative to ensure the person's recovery and stability
- ☐ Likely that the person will benefit from participation in CARE

Summary & Notes: Please summarize any relevant facts pertaining to your consultation request or referral. Please include any information you think DPH needs to know to determine the participant's eligibility for CARE Court. You may also include additional documentation to support your request.

SACRAMENTO COUNTY

CARE COURT
Consultation & Referral

7001 – A East Parkway Sacramento, CA 95823
Email: dhs-bhs-care_court@saccounty.gov | Phone 916-875-9668

Referral determination
Please fill out completely

Date Referral Received:	**Person reviewing request:**
Emergency Assistance Referral: ☐ *Crisis & Referral* ☐ *Information & Referral*	☐ *Processed* ☐ *Closed*

Engagement Attempts:

Date	Method (Face to Face, Phone, Telehealth, Email)	Outreach and Engagement Team Member	Who was contacted(Client, Collateral, Tx Provider)	Contact Made	Information Obtained
	Select One				
	Select One				
	Select One				
	Select One				
	Select One				
	Select One				
	Select One				

Date Processed /Closed:	*Person who processed/closed referral.*