TARZANA TREATMENT CENTERS
Integrated Healthcare

BEHAVIORAL HEALTH REFERRAL FORM

Date of Referral: _____

Client Information

Name of Youth:_____ Grade:_____ DOB:_____

Guardian: _____ Relation to Youth: _____ Preferred Language:_____

Address: _____

Phone: _____ Alternative Phone:_____

☐ Medi-Cal /Insurance Card #: _____ Insurance Plan: _____☐ N/A

Parent/Guardian signature: (if possible)_____

Referral Information

Name of Agency and/or Person making referral:

_____

_____

Contact number: _____ Fax #:_____ Email:_____

Reason for referral:

☐ Depressed mood ☐ Difficulty Sleeping ☐ Irritable/Easily Angered ☐ Nervous/Anxious ☐ Trauma

☐ Crying Spells ☐ Low Self Esteem ☐ Mood Swings ☐ Difficulty concentrating

☐ Hallucination ☐ Fidgety/Restless ☐ Thoughts of hurting self ☐ Thoughts of hurting others

☐ Other, Explain: _____

Substance Use: ☐ Alcohol ☐ Marijuana ☐ Opioids (Vicodin, Heroin, etc.) ☐ Tobacco ☐ Inhalants ☐ Ecstasy

☐ Benzodiazepines (Valium, Xanax, etc.) ☐ Amphetamines (Cocaine, Adderall, etc.) ☐ Unknown

☐ Others:_____

Once completed, please FAX this form to: 1 (818) 936-0137

Or Email to tzyouthnavigation@tarzanatc.org

Please call for more information or to set up an appointment

Tarzana Treatment Centers Youth Outpatient

1 (818) 996-1051 ext. 3100