Behavioral Health Services
Prevention & Intervention Division

Fax

To:		**From:**	
Fax:		**Pages:**	
Phone:		**Date:**	

Please select the Prevention & Intervention program you are referring to:

☐ **Community Counseling and Supportive Services (CCSS)/Orange County Acceptance through Compassionate Care Empowerment and Positive Transformation (OC ACCEPT)**
CCSS is a short-term counseling program for Orange County residents with a mild to moderate behavioral health condition and limited or no access to care. Additionally, the program also provides counseling services for the hard of hearing community, the Arabic speaking community, and the Lesbian, Gay, Bisexual, Transgender, Intersex and/or Questioning+ (LGBTIQ+) community and the people important in their lives.

Phone: (714) 645-8000
Fax: (714) 954-2985
Email: PEICCSS@ochca.com

☐ **Orange County Center for Resiliency, Education and Wellness (OC CREW)**
OC CREW serves youth ages 12 to 25 years who are experiencing a recent first episode of psychosis with symptoms that onset within the last 24 months.

Phone: (714) 480-5100
Fax: (714) 939-2078
Email: OC_Crew@ochca.com

☐ **Orange County Parent Wellness Program (OCPWP)**
OCPWP is an early intervention program for at-risk and stressed families with children under the age of 18. This includes pregnant women and their partners who are affected by the current pregnancy or have a child within the last 12 months, a parent/caregiver who is experiencing mild to moderate behavioral health symptoms that may be negatively impacting their child's readiness for school, or families that have been reported to Child Protective Services for allegations of child abuse or neglect.

Phone: (714) 480-5160
Fax: (714) 939-2079
Email: OCParentWellness@ochca.com

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Behavioral Health Services
Prevention & Intervention Division
Referral Form

For Office Use Only:

MRN: 1000- _________-___________

FIN: 100- __________-___________

Program Participant is Being Referred to: ☐ **CCSS** ☐ **OC CREW** ☐ **OCPWP**

Referral Source Information		
Referral Source:		Date of Referral:
Name	**Title**	**Email Address**
Address:		
Agency:	( )	( )
	Telephone Number	**Fax Number**

Participant Information		
Participant Full Name:	DOB: / /	Gender: ☐Male ☐Female ☐FTM ☐MTF ☐Non-binary ☐_____
Telephone Number:	Primary Language:	Other Language:
Address:		
Street Address Apt	**City**	**Zip Code**

Parent/Legal Guardian Name (If under 18):	Parent/Legal Guardian Name (If under 18):
Telephone Number:	Telephone Number:
Family Language:	Type of Medical Insurance (Participant):

Reason for Referral/Comments

Referral Disposition (For Office Use Only)

☐ Declined Services ☐ Unable to Locate/No Response From Participant
☐ Did Not Meet Program Criteria ☐ On Waitlist

Screened Date: ______________________________ Screened By: ______________________________________

Intake/Orientation Date: ___________________ @___________ am pm Clinician:_______________________ ☐ No Showed

2nd Intake offered Date: ___________________ @___________ am pm Clinician:_______________________ ☐ No Showed

☐ Participant is enrolled in the program and assigned to PC: ____

Comments/Outcome of referral linkage: