STATE OF CALIFORNIA
DIVISION OF JUVENILE JUSTICE
Referral to Inpatient Psychiatric Programs
DJJ 8.207 (REV 12/10) Page 1 of 5

DEPARTMENT OF CORRECTIONS AND REHABILITATION
Facility Name: _____ Date: _____

Referral Form for DJJ Youth to Inpatient Psychiatric Programs

ACUTE CARE PROGRAMS:

- ☐ Sierra Vista Hospital (**SVH**)
- ☐ HGSYCF Correctional Treatment Center (**CTC**)
- ☐ Other Acute Program _____

Check ALL applicable criteria for Acute:

- ☐ Danger to Self: Youth presents an imminent danger to himself due to self-injury due to a mental disorder.
- ☐ Danger to Others Due to a Mental Disorder: Youth presents an imminent danger to others due to a mental disorder (other than a disruptive behavioral disorder or antisocial personality disorder.
- ☐ Gravely Disabled: Youth is unable to provide for himself the basic necessities of life (feeding, clothing, hygiene) due to a mental disorder.

INTERMEDIATE CARE PROGRAMS:

DJJ's ICF:

- ☐ SRCC Intermediate Care Facility **(ICF)**

State Hospital (check desired facility)

- ☐ Metropolitan State Hospital **(MSH)**
- ☐ Napa State Hospital **(NSH)**
- ☐ Patton State Hospital (**PSH**)

Current Clinical/Custody Placement: ☐ CTC ☐ ICF ☐ SCP ☐ ITP ☐ IBTP ☐ GP ☐ SMP/BTP ☐ SVH ☐ MHRU

Youth Name: _____ (YA) DJJ ID#: _____ Date of Birth: _____

Any WDP Issues? ☐ Yes ☐ No Disability: _____ Ethnicity: _____

***KEYHEA**: ☐ Yes ☐ No ☐ In Process (incl. supporting documentation!) Date Initiated: _____ Date Expires: _____

ACT end date: _____ Education: (years) _____ GED: ☐ YES ☐ NO Literate: ☐ YES ☐ NO

Referring Clinician: _____ Ph: _____ Cell: _____ Fax: _____

Tx Psychiatrist: _____ Ph: _____ Cell: _____ MH Clerical Ph: _____

CWS/PA-I (case manager): _____ Ph: _____ Cell: _____

Watch Commander Phone Number (for after hours emergencies): _____

Current Psychiatric Diagnosis: (Space to write: 2 lines)

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V

Current Psych Medications: (name, dosage, freq, duration, target sxs)

Reason For Referral: (check all that apply and supply *detailed* narrative)

☐ **Inadequate level of functioning in current MH unit**: (Space to write: 4 lines)

E-mail and Fax to 1) MH Program Administrator, Health Care Services (paul.woodward@cdcr.ca.gov) and Fax to 2) Intake Coordinator

NAME: LAST, FIRST _____

YA# _____ DOB _____

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☐ **Requires 24-hour nursing care:** (Space to write: 2 lines)

☐ **Requires neurological/neuropsychiatric/diagnostic testing:** (Space to write: 2 lines)

☐ **Would benefit from focused skills development not available in current MH placement**: (Space to write: 5 lines)

Current Mental Status Exam: (Space to write: 2 lines each)

Appearance: ☐ WNL _____

Behavior: ☐ WNL _____

Speech: ☐ WNL _____

Mood: ☐ WNL _____

Affect: ☐ WNL _____

Sleep: ☐ WNL _____

Appetite: ☐ WNL _____

Cognition: 1) Fund of information: ☐ WNL _____

2) Intellectual Functions: ☐ WNL _____

3) Organization of Thought : ☐ WNL _____

4) Association of Thought: ☐ WNL _____

5) Reality Contact: ☐ WNL _____

6) Thought Quality: ☐ WNL _____

Perception Disturbances (Hallucinations): ☐ None _____

Thought Content (Delusions): ☐ None _____

Sensorium (Orient'n, Mem, Attent'n, Concent'n): ☐ WNL _____

Insight & Judgment: ☐ WNL _____

Interview Attitude: ☐ WNL _____

Reliability (Historian): ☐ Good ☐ Fair ☐ Poor _____

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YA# _____ DOB _____

What are the desired **Treatment Outcome Expectations** from this inpatient program? (be very specific) (Space to write: 9 lines)

History of Present Illness and Past Psychiatric History: (Must Fill Out Completely

Hx and Recent **Suicidal or Axis I related Ritualistic or Repetitive Self-Injurious Behaviors**: (Space to write: 5 lines)

Hx and Current **Violence and Behavioral Alerts (include list of commitment offenses)**: Specify gang affiliation and level of involvement (Space to write: 5 lines)

Hx and Current **Substance Abuse**: (Space to write: 4 lines)

Hx and Current **Psychiatric Treatment / CTC / Hospitalization**: (Space to write: 10 lines)

Hx and current **Medication Compliance** (include any history of cheeking/palming, hoarding or purging of medications): (Space to write: 8 lines)

Facility Name: _____ Date: _____

Referral to Inpatient Psychiatric Programs

DJJ Referring Clinician: Comments Regarding ***Clinical Criteria / Factors / Signs / Symptoms*** for Inpatient Placement Consideration

(Space to write: 10 lines)

DIETARY INFORMATION:

Any known food allergies? ☐ YES ☐ NO If yes, explain in detail: (Space to write: 4 lines)

Any dietary restrictions? ☐ YES ☐ NO If yes, explain in detail: (Space to write: 5 lines)

APPROVED VISITORS (per Youth Information Network/WIN):

Name	Relationship	Address	Phone

DISAPPROVED VISITORS (per Youth Information Network/WIN):

Name	Relationship	Address	Phone

E-mail and Fax to 1) MH Program Administrator, Health Care Services (paul.woodward@cdcr.ca.gov) and Fax to 2) Intake Coordinator

NAME: LAST, FIRST _____

 YA# _____ DOB _____

DEPARTMENT OF CORRECTIONS AND REHABILITATION

Facility Name: _____ Date: _____

FOR DJJ YOUTH UNDER THE AGE OF 18, PROVIDE THE CONTACT INFORMATION FOR PARENT/GUARDIAN (for providing consent for medications):

Parent/Guardian Name(s): _____

Address (Street/City/State/Zip): _____

Home Phone: _____ Other Phone: _____

Parent/guardian willing to provide consent for psychotropic medications prescribed in DJJ? ☐ YES ☐ NO (if yes, provide copy)

If not, has the committing judge provided consent via a JV-220 form? ☐ YES ☐ NO (if yes, provide copy)

Referring Clinician Signature: _____ Date : _____

_____
Type Referring Clinician's Name (above)

A copy of this document **CAN NOT** be saved to your computer. Remember to print a copy.

Instructions for processing completed referral form:

1. Print a hard copy of completed referral form by clicking on the button "Print Form" at the top of this page. Sign this form and set it aside for the moment.
2. Send an electronic copy of the completed referral to Paul Woodward by clicking on the button "Submit by Email" at the top of this page.
3. Close the referral form by clicking on the "X" in the red box in the upper right corner of the tool bar.
4. Fax the completed, signed referral form to the intake coordinator at the inpatient psychiatric program of choice (refer to list below these instructions) and to Paul Woodward at fax (916) 262-1087.
5. Send an e-mail notification to the intake coordinator (or designee) and to Paul Woodward with the subject line: CONFIDENTIAL FAX SENT - Inpatient Referral of DJJ Youth.
6. Make telephone contact with the intake coordinator (or designee) and with Paul Woodward (916-838-2108) to ensure that they know that the fax has been sent to them.
7. Compile the additional documents needed to complete the referral packet.
8. Fax the entire packet to the intake coordinator at the inpatient psychiatric program.
9. Mail a copy of the entire packet to CDCR - DJJ Health Care Services, 4241 Williamsbough Drive, Suite 216, Sacramento, California, 95823. Attn: Paul S. Woodward, MH Program Administrator.
10. Place signed (original) DJJ 8.207 referral form in the MH section of the DJJ Unified Health Record.

Inpatient Psychiatric Program Contact Information:

Program	Intake Coordinator	Phone	Fax#	Email
ICF	Doug Strosnider	(562) 868-9979 x 2505	(562) 868-8775	doug.strosnider@msh.dmh.ca.gov
MSH	Alonzo Townsell	(562) 651-4456	(562) 863-8031	atownsel@dmhmsh.state.ca.us
NSH	Stacy Cone	(707) 254-2377	(707) 253-5684	scone@dmhnsh.state.ca.us
PSH	Susan Thompson	(909) 425-7864	(909) 425-0160	STHOMPSO@dmhpsh.state.ca.us
SVH	Mike Swauger	(916) 288-0316	(909) 688-5440	michael.swauger@psysolutions.com

E-mail and Fax to 1) MH Program Administrator, Health Care Services (paul.woodward@cdcr.ca.gov) and Fax to 2) Intake Coordinator

NAME: LAST, FIRST _____