

**Nevada County Behavioral Health**  
**Assisted Outpatient Treatment Referral**

Referring Party Name and/or Agency: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Party Contact Phone Number/s: \_\_\_\_\_

Candidate Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Candidate Contact Phone Number/s: \_\_\_\_\_

Insurance:    MediCal \_\_\_\_\_ CMSP \_\_\_\_\_ Medicare \_\_\_\_\_ Private \_\_\_\_\_

Why are you referring this candidate?

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What is the candidate's current living situation?

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What type of treatment do you think candidate needs in order to survive safely in the community?

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Please check all the county agencies currently involved with candidate.

Outpatient Services:

Outcome was: \_\_\_ Poor \_\_\_ Fair \_\_\_ Successful

Drug & Alcohol Treatment:

Outcome was: \_\_\_ Poor \_\_\_ Fair \_\_\_ Successful

Other (Please List) \_\_\_\_\_

Outcome was: \_\_\_ Poor \_\_\_ Fair \_\_\_ Successful

Please check all the following criteria that apply to the candidate.

18 years or over

Has be offered voluntary treatment

Condition is deteriorating

Has been in hospital, jail or prison. How many times? \_\_\_\_\_

Has made serious or violent threats toward self or others? How many times?

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Please submit this form to Nevada County Behavioral Health, 500 Crown Point Circle, Ste 120, Grass Valley, CA 95945 or fax form to (530) 271-0257. Please call (530) 265-1437 if you have any questions.