

## NORTH COUNTY S.A.F.E. MEETING REFERRAL FORM

S.A.F.E. Office Use Only
Reviewed by: _____
Case Manager: _____

Region North County S.A.F.E. PH: 805-503-9638 Fax:805-462-8901 Email: [cdelreal@linkslo.org](mailto:cdelreal@linkslo.org)

Referral Date \_\_\_\_\_ Referred By \_\_\_\_\_

Referring Agency \_\_\_\_\_ Referral Phone \_\_\_\_\_

Email Address \_\_\_\_\_

**REQUESTED ATTENDANCE:**

Name/Affiliation (Besides SAFE Team members) \_\_\_\_\_ Phone \_\_\_\_\_ Email Address \_\_\_\_\_ Contacted \_\_\_\_\_

School Contact: _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Office use only:** Pre-Staffing \_\_\_\_\_ Meeting Start Time \_\_\_\_\_ Location \_\_\_\_\_  
 Scheduled SAFE date/time \_\_\_\_\_ date/time \_\_\_\_\_  
 Transportation Needed     Translation needed    Case previously presented:  No  Yes    Date \_\_\_\_\_

CHILD'S NAME	AGE	ADDRESS			CITY	ZIP
PHONE NUMBER	GRADE	DOB	SCHOOL OF ATTENDANCE		Current Placement	Sex    Ethnicity*
MOTHER'S NAME	DOB	PHONE	Ethnicity*	Legal Guardian's Name (if different)		PHONE
Mothers Address (if different, include city/zip)				Relationship to child		
FATHER'S NAME	DOB	PHONE	Ethnicity*	Address (if different, include city/zip)		
Father's Address (if different, include city/zip)						
SIBLING	Living in Same home	Yes/Nc	DOB	Sex	Ethnicity*	GRADE    SCHOOL    Others Living in the Home    DOB
SIBLING	Living in Same home	Yes/Nc	DOB	Sex	Ethnicity*	GRADE    SCHOOL
SIBLING	Living in Same home	Yes/Nc	DOB	Sex	Ethnicity*	GRADE    SCHOOL
SIBLING	Living in Same home	Yes/Nc	DOB	Sex	Ethnicity*	GRADE    SCHOOL

**CURRENT STATUS/OPEN CASES**

<p><b>Closed</b></p> <input type="checkbox"/> DSS <input type="checkbox"/> CWS <input type="checkbox"/> Probation <input type="checkbox"/> Mental Health <input type="checkbox"/> Public Health <input type="checkbox"/> Spec. Ed. <input type="checkbox"/> D & A <input type="checkbox"/> Other	<p><b>Open</b></p> <p><b>Staff</b>    <b>Case#</b></p> <input type="checkbox"/> _____ / _____ <input type="checkbox"/> _____ / _____ <input type="checkbox"/> _____ / _____ <input type="checkbox"/> _____ / _____ <input type="checkbox"/> _____ / _____ <input type="checkbox"/> _____ / _____ <input type="checkbox"/> _____ / _____
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**FINANCIAL STATUS**

<input type="checkbox"/> Medi-Cal	<input type="checkbox"/> CalWORKs (families)
<input type="checkbox"/> Insurance (private)	<input type="checkbox"/> AFDC-FC (foster child)
<input type="checkbox"/> Healthy Families	<input type="checkbox"/> Other _____

**\*ETHNICITY CODES**

10 Native American	50 Hispanic
20 Asian	60 African American
30 Pacific Islander	70 White
40 Filipino	90 Other _____

Previous Placement (date) \_\_\_\_\_

Medical Concerns/Medication(s) (Note MD's name) \_\_\_\_\_

Current Therapist/Psychiatrist \_\_\_\_\_  
Name

\_\_\_\_\_ Phone Number

Student/Child/Family Strengths:

**Presenting concerns/specific reasons for referral.** Information on siblings is extremely helpful.

1. Presenting concerns/specific reasons for referral:

- |   |   |
|---|---|
| <input type="checkbox"/> Substance Use          | <input type="checkbox"/> Employment Concerns          |
| <input type="checkbox"/> Parent Child Conflict  | <input type="checkbox"/> Child Behavioral Concerns    |
| <input type="checkbox"/> Loss/Grief             | <input type="checkbox"/> Educational Concerns         |
| <input type="checkbox"/> Homelessness           | <input type="checkbox"/> Criminal Behavior by parent  |
| <input type="checkbox"/> Domestic Violence      | <input type="checkbox"/> Criminal Behavior by youth   |
| <input type="checkbox"/> Financial Stress       | <input type="checkbox"/> Child Developmental Concerns |
| <input type="checkbox"/> Child Abuse/Neglect    | <input type="checkbox"/> Bonding/Attachment Concerns  |
| <input type="checkbox"/> Medical Concerns       | <input type="checkbox"/> Other _____                  |
| <input type="checkbox"/> Mental Health Concerns |   |

2A. What would the referring party like to see happen at the meeting/purpose?

2B. What would the family like to see happen at the meeting?

3. How are attendance, siblings, behavior, etc.?

4. What current services/agencies is the family already connected to?

5. Does the family need immediate assistance from a family advocate? Are they Spanish speaking?

*This document is protected by various federal and state laws including HIPAA, California Medical Information Act, Welfare and Institutions Code 5328, and 42CFR Part2. By accepting this document, you are now a legal holder of protected health information and are required to protect this document and the information therein from disclosure to unauthorized individuals or entities. Disclosure may mean oral, electronic, or via paper, and improper disclosure of this information may be a crime under federal and/or state law. If this document contains information originating at a Drug and Alcohol Treatment program covered by 42CFR Part2, (including County of San Luis Obispo Drug and Alcohol Services), then 42 CFR part 2 prohibits unauthorized disclosure of these records.*