POSITIVE SOLUTIONS
A program of Union of Pan Asian Communities
REFERRAL FORM

Please email this form to yesquivel@upacsd.com Attn: Program Manager or, **Today's date:**

Call us at 619-481-2652 with the following information to make the referral.

Services may be provided via telehealth or in-person.

* **Required Fields.**

IS THE INDIVIDUAL:

***At least 60 years old?**	☐YES ☐ NO
***Homebound or socially isolated?**	☐YES ☐NO
***Depressed, overwhelmed or at risk?**	☐YES ☐NO
Having suicidal thoughts, homicidal thoughts or in crisis?	☐YES ☐ NO
Showing signs of dementia or any other type of cognitive impairments?	☐YES ☐NO
If yes, please describe what is observed:	
Having a psychotic episode? (Hallucinations, bizarre thoughts, etc.)	☐YES ☐NO
*Currently receiving mental health services?	☐YES ☐NO
If yes, please provide name of service provider:	

CONTACT INFORMATION FOR OLDER ADULT

*Last Name *Name *Address: *City: *Zip Code

*Phone Number: *DOB *Language(s): Monolingual? ☐YES ☐ NO

*Trusted Emergency Contact by Elder (if applicable): *Relation *Phone Number:

*Gender: Age:

REFERRING PARTY INFORMATION

Person Making Referral: Phone Number:

CLINICAL INFORMATION

*Client report of problem/goal:

Psychotropic medications?

Case management issues directly related to mental health:

Safety issues (pets, odors, environment):

Significant life events and physical limitations (specific dates):

Additional information:

History of Addiction or Substance Use ? ☐ UNKNOWN ☐ NO ☐ YES If Yes, approximate date of last use:

Substance(s) of Choice:

History of Treatment(s) for Drug/Alcohol or Co-Occurring issues:

Risk factors: (gambling, suicide attempts, SI, HI, command AH, property damage, threats, risky behaviors):

Person Completing Referral: Title: Date:

Preffered Call Times:

PSP Office Use Only

Client #

For Internal Use Only

: