Northeast Valley Health Corporation
a california health+ center

Date Received		
Dates of Attempted Contact	1)	2)
Date Closed	Date of Intake	

L.A. MISSION COLLEGE STUDENT HEALTH CENTER
REFERRAL FORM

Referral Date: ____/____/_____

Contact information for student being referred:

Name: _____ DOB: ____/____/_____ M___ F___

Address: _____ Insurance: _____

Home/ Cell Phone #: (_____) _____-_____ Work Phone #: (_____) _____-_____ Language: _____

Emergency Contact Name/ Phone/ Language: _____

PLEASE CHECK ALL THAT APPLY:

Referral to: __Behavioral Health * __Case Management __Community Resources __Insurance Enrollment
__Medical Services __Medication __Pregnancy Options

Referred by LAMC source: __Faculty/ Staff __Academic Counseling __CATS __DSPS __EOPS Other: _____

Referred by other source: __Self __Friend/ Acquaintance __Family Member __Tierra Del Sol Other: _____

Contact information for person making the referral:

Name: _____ Phone #: (_____) _____-_____

Explain reason for the referral: _____

Student's response to the referral (Interested/ Unsure, Additional Comments)**:** _____

I, _____ agree to be contacted by NEVHC L.A. Mission College Student Health Center
Student's Name
for behavioral health services. _____ _____
Student's Signature Date

*** PLEASE CHECK ALL THAT APPLY:** **Severe Symptoms/ Behavior**

__Suicidal ideation __Homicidal ideation __Other verbal threats __Self harm __Delusional ideation ___Erratic behavior

For 1st response to students on campus who are suicidal, homicidal, harming themselves, or demonstrate other severe or inappropriate behavior, call the on-campus Sheriff's office. When using the L.A. Mission College phone system to call the Sheriff, dial 7843. When using a cell phone, dial 818-364-7843. If the student is *off campus, call 911 or the L.A. Co. Department of Mental Health Access Line at 800-854-7771.*

Other Symptoms/ Behavior

__ Sad/ Crying
__ Isolates/ Withdraws
__ Sleep problems
__ Grief from losses
__ Fearfulness/ Anxiety
__ Panic Attacks
__ Eating disorder
__ Poor hygiene
__ Easily distracted
__ Easily angered/ Irritable
__ Defiant toward rules
__ Impulsive/ Provokes others
__ Intoxicated
__ Other _____

Academic Performance/ Classroom Behavior

__ Learning disability risk factors __ Struggling/ Failing __ Misses class __ Disruptive

History

__ Socio-economic instability
__ Psychiatric hospitalizations
__ Family instability
__ Drug/ Alcohol use
__ Housing instability
__ Legal system interaction
__Violence

Clinician's notes: _____

Patient Label

Please return completed referral and Authorization to Release Information to Sofia Luna at Email: sofialuna@nevhc.org Fax: 818-367-2340

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AUTHORIZATION TO RELEASE INFORMATION

Date of Service: _____ Time: _____ Loc: _____
Patient Name: _____ Chart # _____
Address: _____ City: _____
Home: (___) _____ Emg: (___) _____
DOB: ___/___/___ Sex: _____ Age: ____ Act# _____
Ins. Plan: _____
(PLACE LABEL HERE)

SECTION 1

I understand that signing or choosing not to sign this form will in no way affect the quality of care I receive at Northeast Valley Health Corporation. I authorize Northeast Valley Health Corporation to release, receive and share the following information for the purpose(s) of diagnosis, treatment and referral by initialing each of the appropriate lines below:

_____ Initial — Entire Medical Record

_____ Initial — Hospital Discharge Summary (CCD)

_____ Initial — Other: Referral Status (Please Specify)

_____ Initial — HIV Test Result(s)

_____ Initial — Substance Use/Abuse History

_____ Initial — Mental Health Information

Authorization is hereby given to:

Agency Name: NEVHC-LA Mission College Student Health Center
Address: 13356 Eldridge Ave
City, State, Zip Code Sylmar, Ca 91342
Phone Number: 818-362-6182
Fax Number: 818-367-2340

To Release Information To:

Agency Name: Los Angeles Mission College
Address: 13356 Eldridge Ave
City, State, Zip Code Sylmar, Ca 91342
Phone Number: 818-364-7600
Fax Number: _____

This authorization is valid for one year from the date it is signed and may be revoked at any time by verbally informing an employee of NEVHC and/or signing the revocation line below. I understand that I may request a copy of this form for my personal records. I understand that information used or disclosed with this authorization may be subject to disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA).

Patient/Parent/Guardian Signature: _____ ____ / ____ / ____ Date Signed (mm,dd,yy)

Witness Signature: _____ ____ / ____ / ____ Date Signed (mm,dd,yy)

SECTION 2

Revocation/Cancellation of Release

Print Name: _____

Patient/Parent/Guardian Signature: _____ ____ / ____ / ____ Date Signed (mm,dd,yy)

If cancellation is made via telephone, please note on signature line and print name

Original to Med Record; Copy to Agency; Photocopy provided to Patient/Client upon request

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AUTORIZACIÓN PARA OTORGAR INFORMACIÓN

Date of Service: _____ Time: _____ Loc: _____
Patient Name: _____ Chart # _____
Address: _____ City: _____
Home: (___) _____ Emg: (___) _____
DOB: ___/___/___ Sex: _____ Age: ____ Act# _____
Ins. Plan: _____
(PLACE LABEL HERE)

SECCIÓN 1

Entiendo que al escoger firmar o no firmar este documento, no afectará la calidad del cuidado que recibo de Northeast Valley Health Corporation. Yo autorizo a Northeast Valley Health Corporation a otorgar, recibir y compartir la siguiente información para el propósito(s) de diagnóstico, tratamiento y referencia. Por favor ponga sus iniciales en las lineas apropiadas.

_____ Inicial — Archivo Médico Completo

_____ Inicial — Resúmen de Alta Hospitalaria (CCD)

_____ Inicial — Otro: Estado de referencia

_____ Inicial — Resultado(s) de mi Prueba de VIH

_____ Inicial — Historia de Uso/Abuso de Substancias químicas/drogas

_____ Inicial — Historia de Salud Mental

Esta autorización es otorgada a:

Nombre de la Agencia: NEVHC-LA Mission Student Health Center
Dirección: 13356 Eldridge Ave
Ciudad, Estado, Código Postal: Sylmar, Ca 91342
Número de Teléfono: 818-362-6182
Número de Fax: 818-367-2340

Para otorgar información a:

Nombre de la Agencia: Los Angeles Mission College
Dirección: 13356 Eldridge Ave
Ciudad, Estado, Código Postal: Sylmar, Ca91342
Número de Teléfono: 818-364-7600
Número de Fax: _____

Esta autorización es válida por un año a partir de esta fecha y usted tiene el derecho de revocar esta autorización en cualquier momento notificando verbalmente a un empleado de NEVHC y/o firmando la línea de revocación de abajo. Entiendo que puedo pedir una copia de esta forma para mis archivos personales. Entiendo que la información usada o revelada con esa autorización puede estar sujeta a la divulgación por el beneficiario y no podrán ser protegidos por la Ley de Responsabilidad y Transferibilidad de Seguros Médicos (HIPAA).

Firma del Paciente/Padre/Apoderado: _____ _____ / _____ / _____ Fecha de la firma (mes,día,año)

Firma del Testigo: _____ _____ / _____ / _____ Fecha de la firma (mes,día,año)

SECCIÓN 2

Revocación/Cancelación de Autorización

Imprima el Nombre: _____

Firma del Paciente/Padre/Apoderado: _____ _____ / _____ / _____ Fecha de la firma (mes,día,año)

Si la cancelación se realiza a través del teléfono, por favor, escríbalo en la línea de la firma así como su nombre

Original al Archivo Médico; Copia a la Agencia; Fotocopia para el Paciente/Cliente si lo solicita