REQUEST FOR SERVICES - STEPS PROGRAM

4660 Viewridge Avenue San Diego, CA 92123
Phone: (858) 565-2510 Fax: (858) 565-0827

Date: _____ Youth being referred: _____

Social Security Number: _____DOB: _____ Age: _____

Medi-cal: ☐YES ☐NO Medi-Cal #:_____

Parent/Caregiver Name(s):_____

Phone Number: _____

Address: _____

Youth Address & Phone Number (if different from above):_____

Youth Ethnicity and Preferred Language: _____

Parent/Caregiver Ethnicity and Preferred Language: _____

School/District: _____ IEP: ☐YES ☐NO

Referring Party Name/Agency: _____

Phone Number:_____

Email Address: _____

Please describe the reason for the referral including specific sexually abusive behaviors:

Please provide mental health treatment including dates, provider, diagnosis and psychiatric hospitalizations:

Please list current medications and prescribing doctor:

Please describe current or historical verbal and/or physically aggressive behavior:

Please describe current and/or historical substance use:

Please describe current potential for harm including high risk behaviors; ie self-injurious behavior, suicidal ideation, homicidal ideation:

Please list any physical health concerns and/or allergies:

****Please provide all available supporting documentation. This may include:**

Behavioral Health Assessment
Psychological Evaluation
Social Study
Individualized Education Plan
CWS Detention or JD Reports
Authorization to use or Disclose Protected Health Information (04-24AP/04-24AC)
Any other documentation pertaining to the reason for the referral

Thank you for taking the time to make a referral to STEPS. We will be contacting you and/or the caregiver to schedule a screening. Please let us know your preferred days and times:_____

For questions or additional information, please contact the Program Manager: Adam Beer, LMFT ABeer@mhsinc.org or Program Supervisor: Stephanie Andrews, LMFT SAndrews@mhsinc.org