

CONSENT PAGE

Referral/Screening Source

Referring person: **Telephone No.:**

Referring agency: Public Health CFS Vista Del Mar Probation

School: First 5:
 VCMC Program: Other:

Date of referral: **E-Mail Address:** GroupWise

Client Information

Last name: **First name:** **MI:** **Sex:** M F

Ethnicity: Latino Caucasian African American Other

Primary Language: English Spanish Other: **Date of Birth:**

Current Residence: Shelter Care Realtive(s) Biological Parent(s) Juvenile Justice Facility
 Foster Care Residential Treatment Facility Other:

Current Services: Early Start Head Start Special Education Public Health First Five TBS
 Regional Center CFS: Worker's Name/Number:
 Probation: Officer's Name/Number: Other:

Insurance Status: Medi-Cal # Healthy Families No Insurance
 Other:

Caregiver/Contact Name: **Relationship to Youth:**

Caregiver Primary Language: English Spanish Other:

Telephone: Home **Work** **Cell**

Address: **City:** **Zip**

English Statement: I hereby give consent for Ventura County Behavioral Health (VCBH) to exchange and release information from this screening with an assigned VCBH provider or affiliated private provider in order to evaluate me / my child for mental health services. I understand that I will be contacted within 7 days by the assigned provider. If I have not been contacted within 7 days or am unsatisfied with the assigned provider, I will call (805) .

Spanish Statement: Por la presente doy consentimiento para que Ventura County Behavioral Health (VCBH) intercambie y de información de esta breve evaluación a un proveedor de VCBH asignado o proveedor privado afiliado para poder evaluar a mi / mi niño(a) para servicios de salud mental. Yo entiendo que se van a poner en contacto conmigo en menos de 7 días para asignar a un proveedor. Si no se han puesto en contacto conmigo en 7 días o menos o si no estoy satisfecho con el proveedor asignado, voy a llamar al (805) .

Parent/Guardian Signature Date

Client Signature Date