

VCBH FOLLOW-UP (Completed by VCBH ONLY)

Clinician conducting follow-up: _____ Date of follow-up: _____

What types of services is the caller interested in?

- Psychiatric Therapy Group Drug/Alcohol Education/Speech & Language
 Housing Health/Medical Parent Ed./Skills Vocation/Employment
 Other

Additional info:

Statement of Consent

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

_____ _____ Phone consent obtained from Client Parent/Guardian
 Staff Signature Date

Ventura County Behavioral Health Confidential Patient Information Welfare & Institutions Code 5328 and Evidence Code 1014	Youth & Family Interagency Screening Follow-Up	Name: _____ ID#: _____ Site #: _____	
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Case Disposition (completed by clinician)

Status Routine No case made (why: _____)
 Urgent: **Must offer** the client/family an appointment that occurs within the next 24 hours
 Emergency: Immediate intervention

Referrals Centralized Screening Other _____

Interventions Contact Police Contact CIRT Parent informed about CIRT CFS report - date _____
 Other: _____

Triage (completed by centralized screening team)

Refer out Provider Network: _____ Access Line
 NFL: _____ Client's private insurance
 Other: _____

Refer in (VCBH) Clinic/Prog: _____ Psychiatrist: _____
 Clinician: _____ Other: _____

Other referrals CMC Med Clinic Healthcare for Kids Pub. Health Regional center
 United Parents Other: _____

Outreach Information (completed by VCBH/contractor staff as referral is processed)

Date of first contact with clinic: _____
 Date screen completed: _____
 Clinician appt: Date 1st available _____ Physician appt: Date 1st available _____
 Clinician appt: Date 1st made _____ Physician appt: Date 1st made _____
 Clinician appt: Date 1st seen _____ Physician appt: Date 1st seen _____
 If VCMC referral, date results sent to physician _____

Outreach attempts: _____

Final disposition: _____

Comments: _____

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