SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

# SPPN REFERRALS
# ONLY FOR SED YOUTH

**Email to: HS_BHRS_Call_Center_PPNReferrals_Internal@smcgov.org**

| | | |
|---|---|---|
| **Name of Care Coordinator:** | | **Phone:** |
| **Name of Client:** | | **Preferred Name:** |
| ***Legal guardian:*** | | **Preferred Pronouns:** |
| ***Name of Caregivers:*** | | |
| ***Mother:*** | | ***Father:*** |
| **DOB**: | **MHN:** | **Primary Diagnosis:** ***ICD-10 must match most recent assessment*** |

| | |
|---|---|
| **Client Preferred Language:**<br><br>**Caregiver Preferred language:** | **SPPN <u>does not accept</u>** Medicare Noridian only, ACE, Restricted MediCal, private insurance & no insurance. ***Please attach proof of insurance (HPSM Trio and Meds Lite)***<br>**Insurance Verified:** ☐ **Yes** ☐ **No** |
| **Client/Caregiver notified of referral:**<br>☐ **Yes** ☐ **No** | **Insurance type:** _____<br>**Insurance ID No.:** _____<br>**Date checked:** _____ |

**Presenting issues:**

**Therapy Goal and Summary of Current Needs:**

**Current risk of harm to self:** ☐ **Yes** ☐ **No** **Current risk of harm to others:** ☐ **Yes** ☐ **No**

**Current substance use:** ☐ **Yes** ☐ **No**

| | |
|---|---|
| **Reason for referral (check one):**<br>☐ Clinic at Capacity<br>☐ Specialty Care<br>☐ Family Therapy<br>☐ Other: _____<br>**Specialty Care if applicable:**<br>☐ Eating Disorder ☐ DID<br>☐ LGBTQ ☐ DBT<br>☐ EMDR ☐ OCD<br>☐ Other: _____ | **Preferences – Please specify:**<br>☐ Therapist Gender: _____<br>☐ Location: _____<br>☐ Telehealth i.e., Doxy.me, Teams: _____<br>☐ ADA accommodations: _____<br>☐ Language: _____<br>☐ Other: _____ |

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| **Name of Care Coordinator:** | | **Phone:** |
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| **Name of Client:** | | |
| **DOB:** | **MHN:** | **Primary Diagnosis Code (ICD10):** *ICD-10 must match most recent assessment* |

**Most recent treatment plan Start Date:** _____ **End Date:** _____

***Treatment Plan must include all interventions including check boxes that the SPPN provider will be providing (individual therapy, Family Therapy, Group Therapy, Collateral, Case Management)***

| **Intervention** | **Frequency (1 x Weekly, etc.)** |
|---|---|
| **Individual Therapy – (OPPSY)** | _____ X Weekly<br>_____ X Every other week<br>_____ X Monthly<br>_____ X Other or N/A _____ |
| **Family Therapy - (Family Therapy Associated)** | _____ X Weekly<br>_____ X Every other week<br>_____ X Monthly<br>_____ X Other or N/A _____ |
| **Group Therapy** - *If the SPPN provider will be providing Group Therapy, this intervention needs to be included in the treatment plan* **(90853)** | _____ X Weekly<br>_____ X Every other week<br>_____ X Monthly<br>_____ X Other or N/A _____ |
| **Collateral** - *Contact with one or more family members and/or significant support persons* **(90887)** | _____ X Weekly<br>_____ X Every other week<br>_____ X Monthly<br>_____ X Other or N/A _____ |
| **Case Management** - *This code needs to be included in every treatment plan for collaborative consultation with the treatment team. (SPPN providers do not provide case management services to the client.)* ***(T1017)*** | _____ X Weekly<br>_____ X Every other week<br>_____ X Monthly<br>_____ X Other or N/A _____ |

Supervisor Signature: _____

Printed Name: _____