

Mariposa Clubhouse Referral Form

1701 Mission Avenue Ste. 120 Oceanside, CA 92058.

Phone: (760) 439-2785

Fax: (760) 439-6902

Email: MariposaClubhouse@turnbhs.org

Referral Information

| |
|---|
| Name: |
| Date of Birth: |
| Address: |
| City, State, Zip Code: |
| Primary Phone: |
| Email: |
| Sources of healthcare funding/type of healthcare insurance: |
| Interested in applying for Medi-Cal: Yes or No |

Please have your behavioral health provider fill-out the information below.

| |
|--|
| All Behavioral/Mental Health/SUD Diagnoses: |
| Primary Psychiatric Diagnosis: |
| When did they first begin treatment with you?: |
| Have they been engaged in treatment for more than 6 weeks with you or another treatment center? Yes or No |
| Do they regularly attend their appointments? Yes or No |
| Current/Previous Treatment Program: |
| Date of Last Hospitalization: |
| Are medications being used to help symptoms? Yes or No |
| Current Living Situation: |
| Does the individual pose a concern to the wellbeing of others? Yes or No |
| How well do you believe the individual will engage in our program? |
| Behavioral Health Care Provider's Name: |
| Organization: |
| Address: |
| City, State, Zip Code: |
| Phone: |
| Email: |
| Provider's Signature: |
| Title/License: |
| Date: |