SACRAMENTO COUNTY

COMMUNITY SUPPORT TEAM (CST) REFERRAL FORM

Hours of Operation: Monday – Friday, 8:00 a.m. – 5:00 p.m.
Telephone: (916) 874-6015 **REFERRAL EMAIL:** CSTServiceRequest@saccounty.net

THIS REFERRAL FORM MAY BE USED ONLY FOR NON-EMERGENCY REQUESTS. PLEASE CALL 9-1-1 FOR EMERGENCY SERVICE REQUESTS.

REFERRING PARTY INFORMATION		
Name of Contact:	**Agency & Program Name:**	
Today's Date:	**Time:**	**Telephone Number:**
Fax Number:	**E-mail:**	

SUPPORT REQUESTED FOR			
Name:		**Date of Birth:**	**Age:**
Home Phone:		**Cell Phone:**	**E-mail:**
Address:		**City:**	**Zip Code:**
☐ Male ☐ Female ☐ Other ☐ unk	**Race:** Select Race	**Ethnicity** (Hispanic or Latino): ☐ **Yes** ☐ **No** ☐ **Unknown**	
Primary Language: English		**Interpreter service recommendation:** ☐ **Yes** ☐ **No**	
Can we contact this person directly? ☐ **Yes** ☐ **No** If no, Contact Name and Phone Number:			
Concerns and/or Services Requested (reason for referral, symptoms, behaviors, risks, needs for support)**:**			

***Please identify current stressors or areas of focus for support that would improve sense of health and wellness*:**

☐ Mental Health navigation/resources	☐ housing/ living situation	☐ legal	☐ medical	☐ social / recreational	☐ education/ employment	☐ financial	☐ concrete needs (food/clothing)	☐ safety	☐ self-care

History of Mental Health treatment:	**Use of traditional or alternative healing practices:**
SSN:	**Insurance Coverage : Select Insurance Coverage If Other:**

CST OFFICE USE ONLY	
☐ **URGENT REFERRAL** ☐ **STANDARD REFERRAL**	
REFERRAL RECEIVED BY: Telephone ☐ **Fax** ☐ **E-mail** ☐ **In-Person** ☐	**RECEIVED BY:** **DATE RECEIVED:** **ASSIGNED TO:**

IF THIS IS AN EMERGENCY, PLEASE CALL 9-1-1 FOR EMERGENCY RESPONSE AND SUPPORT SERVICES.