Please mail or fax this form to:

12966 Euclid Street, Suite 425, Garden Grove, CA 92840
Phone: 714-461-3687 | Fax: 714-591-5015

OCAPICA- Project RISE
Referral/Screening Form

CONFIDENTIAL INFORMATION

Referring Person/Title: Agency/Dept: Date:

Email: Phone: Fax:

PARTICIPANT INFORMATION

Name: DOB: Age: Gender Identity:

Address: City: Insurance:

Phone: Ethnicity: Preferred Language:

LEGAL GUARDIAN/ CONSERVATOR INFORMATION

Name: Phone: Relationship to participant:

Address: Preferred Language:

REASONS FOR REFERRAL/ SERVICE

☐ Yes ☐ No Does this case need a bilingual worker? If yes, specify language:
☐ Yes ☐ No Does the staff need to talk with referring person prior to intake?
☐ Yes ☐ No Participant has been notified and consented that RISE staff will contact them?

Services Interested

☐ **Individual Therapy** ☐ **Group/Workshop** ☐ **Case Management** ☐ **Skills Building**

Describe:

Availability for services:

Disposition

☐ Assigned Clinician: _____ Date: _____

☐ Assigned Case Manager: _____ Date: _____

☐ Not Appropriate for Program ☐ Referred to: _____

Initials: