

**COUNTY OF LOS ANGELES-DEPARTMENT OF MENTAL HEALTH
SCHOOL THREAT ASSESSMENT RESPONSE TEAM (START)
REFERRAL FORM**



LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

If this is a psychiatric emergency, please call ACCESS Center 1-800-854-7771 or dial 911.

Please fax this form to (213) 402-3871 or e-mail START@dmh.lacounty.gov.

DATE:

Name:	DOB:	Age:
Preferred Language:	Secondary Language:	Ethnicity:
Reason for Call:		Gender: (Male / Female)
Referring Party Name & Contact:		
School Contacts (Name & Phone #):		Grade:
Student's Therapist:	Phone #:	
Treatment Agency:		
Current Psychiatric Treatment and Medications (List Names and other pertinent information such as compliance with meds):		
If Adult:	Address:	Phone #:
Guardian's Name:	Address:	Phone #:
Father's Phone:	Mother's Phone:	
Father's Address:	Mother's Address:	
Preferred Language:	Preferred Language:	
Primary Caregiver (Complete only if Biological Parent is not the Primary Caregiver)		
Adoptive	Guardian	Foster
Kinship/Relative	Group Home	Other
Name:	Relationship to Child:	
Address:	Phone:	Work:
Length of Time with this Caregiver.		
(CHECK) Current Risk and Safety Concerns		
Current Thoughts of Suicide	Yes	No
Suicide Plan	Yes	No
Past Thoughts of Suicide	Yes	No
Prior Suicide Attempts	Yes	No
Behavioral Problems in School	Yes	No
IEP in Place	Yes	No
History of Bullying	Yes	No
History of Being Bullied	Yes	No
Violent Drawings/Writings	Yes	No
Recent Trauma Exposure	Yes	No
Victim of Violence/Abuse	Yes	No
DCFS Involvement	Yes	No
Probation involvement	Yes	No
Animal Cruelty	Yes	No
Fire Setting	Yes	No
Stalking Behavior	Yes	No
ERMHS	Yes	No
ERICS	Yes	No
Current Thoughts of Harming Another Person	Yes	No
Past Thoughts of Harming Another Person	Yes	No
School Violence Plan	Yes	No
Has a Preoccupation with Violence	Yes	No
Access to Weapons / Explosives	Yes	No
Has a Hit List	Yes	No
Has Injured Others	Yes	No
Prior Psychiatric Hospitalization	Yes	No
History of Self Harm (Cutting)	Yes	No
History of Substance Abuse	Yes	No
Current Substance Use/Abuse	Yes	No
Truancy	Yes	No
Suspensions	Yes	No
Expulsions	Yes	No
Media Research Behavior on the following	Yes	No
(Explosives, Weapons, Terrorist Sites, School Shootings)		

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Any other details:

The content of this form contains protected and confidential information and must be adequately secured to prevent unauthorized access. Should you choose to email the document at the provided email address you are advised to take the necessary precaution.

PLAN/DISPOSITION (START OFFICE USE ONLY)				
IBHIS #/ Name:		Returning Client		
Assigned to:		Date Assigned:		
Violent Risk Level:	High	Moderate	Low	Suicidal Risk Level: High Moderate Low
Status:	Consultation Only	Eligible/Activation		Cannot reach
	Eligible/Decline/Follow-up	Not Eligible/Follow-up		Out of LA County
	Eligible/Decline/No Follow-up	Not Eligible/No Follow-up		Gang-related
If the case is hospitalized: admit date and name of hospital:				
Reason of the Disposition:				
Referred to PMRT	Referred to 911	Referred to other services	Other	
Activation date (For open and close cases that only receive crisis interventions H2011, no activation needed. But if cases are to be actively followed up, must activate)				
Referral recorded by:		Record Date:		Date Received: