Behavioral Health Services
Substance Use Treatment Services
Children, Family and Community Services Division

Adolescent Residential Demographics (ARD)

Date of Referral: Click here to enter a date.

Client Name (please print): ____	Monolingual language need: ____
Client Address: ____	Admit Date: Click here to enter a date.
Parent/Guardian: _____	Monolingual language need: ____
Home Number: ____	Other Numbers: ____

Referral Site: ADVENT-OP Your Name & Phone #: ____

(Required) Medi-Cal EVC Confirmation Number: _____

Court Department: Choose an item. Next Court Date: Click here to enter a date.

Probation Officer: ____ Phone #: ____

In Custody: ☐ Out of Custody: ☐

PATHS Referral: ☐ Probation Only: ☐

Referral Checklist

☐ Parental/Guardian has agreed to sign consents and be involved in Residential Treatment
☐ Client must have Medi-Cal or is unsponsored
☐ Current IEP or 504 is enclosed in referral, if applicable. *
*Does client require Special Day Class (SDC) or Non Public School services? Yes ☐ No ☐

If the client is actively suicidal or has a history of sexual and/or violent offenses they are not appropriate to refer to Residential Treatment

If violent or sexual offenses please elaborate if there are mitigating circumstances. If client is affiliate with a gang, indicate level of involvement and gang name. Other relevant information: