School Based Mental Health Services Referral Form

Please fax to (Mandy Sommers)
(310 313 7652)

School Site: **Brockton Elementary** ________ Grade:______ Age:_____ Date of Referral: ____/____/____

Referred by (Name& Title): ____________________ Phone Number: ____________________

Name of Student: ____________________ DOB: ___/___/___ M__ F__ Medi Cal #:____________

Parent/Legal Guardian/Child's Attorney: ________________________________

Home #: ____________________ Work/Alternative #: ____________________

Student Language: ____________________ Parent Language: ____________________

Address: ____

REASON FOR REFERRAL: ____

____

Please check any of the following that apply

Risk Factor (Current or Past history of the following behaviors): ***If any of these highlighted behaviors are currently being displayed, please alert your school crisis team immediately.**

__Suicidal Ideation*
__Sexual Abuse*
__Child Abuse/Neglect*
__Homicidal Ideation*
__Runaway Behavior
__Community Violence
__Drugs/Alcohol Concern
__Hallucinations

Actions taken by school prior to initiating a service request:

__Class modification
__Study Team
__Contract Behavior
__Parent conference
__Suspension
__Detention
__Impact Referral
__IEP
__Previous MH Referrals
__ DIS counseling
__ Resource Specialist

School Performance
__failing grades
__doesn't complete assignments
__lacks motivation/uninterested in school
__frequent tardiness
__reading below grade level
__oral/written skills below grade level
__defiant of rules
__attention problems
__school adjustment problems

Behavior
__isolates
__anxious/nervous
__withdrawn/shy
__shuts down
__defiant towards authority
__aggressive/destructive
__temper tantrums
__gang affiliation
__hyperactive/impulsive

Behaviors
__self harm/cutting
__cheats/steals
__sadness/depression/tearful
__easily angered
__sexualized behavior
__speech problems
__frequent daydreaming
__blames other for their problems
__ impaired social skills

Home Environment
__unstable/overcrowded living conditions
__cares for younger sibling's
__problems with sibling's
__inappropriate/inconsistent discipline
__death/loss of significant other
__divorce/separation
__not living biological family
__family violence/domestic violence

Medical/Physical
__poor personal hygiene
__sleeps in class
__frequent trips to the nurse/somatic complaints
__dental needs
__vision needs
__known medical problems
__wet/soils self
__other: ______________

Parent response to referral: Interested/Unsure ________________________________

INFORMED CONSENT FOR PROVIDER CONTACT

Date: ____________

I hereby authorize ______________________________ school to disclose contact information regarding
School Name

____________________________, date of birth________________. This information is being given
Student Name

to assist my child to obtain mental health services by **The Help Group-Outpatient Department**.

Provider is not a part of the regular and ongoing program of the school or the Los Angeles Unified School District. This service is made available at the school/site for my convenience to obtain mental health services for my child. *I understand that the Los Angeles Unified school District does not assume responsibility for the services provided by the Provider nor for fees that may be charged.*

____________________________ ______________________

Signature of Parent/Legal Guardian Date

CONSENTIMIENTO PARA INTERCAMBIAR INFORMACIÓN

Fecha:____________

Yo autorizo que ______________________ de información referente a ______________________,
Nombre de escuela Nombre de estudiante

_____________. Esta información será dada solo para ayudar a mi hijo(a) obtener servicios de salud

mental por **The Help Group-Outpatient Department**.

Yo entiendo que este programa no esta asociado con LAUSD. La escuela provee el espacio para este programa como un servicio comunitario. LAUSD no es responsable por ningún pago que tal vez sea requerido.

Please initial if verbal consent was given ___

Please Fax to (Mandy Sommers)
310-751-1178 Direct Line
310-515-7652 Fax Number