



PASADENA UNIFIED SCHOOL DISTRICT

Mental Health Services - Referral Form

2046 N ALLEN AVE #100, Altadena CA 91001 - Phone: (626) 396-5920 Fax: (626) 791-6251
 Email: mentalhealth@pusd.us

Student Information

| | |
|--|-------------------------------|
| Name: _____ | Date of Referral _____ |
| School: _____ Grade: _____ | Student PUSD ID# _____ |
| Referring Person: _____ | Referring Person Ph. #: _____ |
| Referral Source: <input type="checkbox"/> School Psychologist <input type="checkbox"/> Teacher <input type="checkbox"/> School Administrator <input type="checkbox"/> Nurse <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other | |
| Parent/Caregiver Name: _____ | Parent/Caregiver Ph. #: _____ |
| Parent/Caregiver Language: _____ | Student DOB: _____ |

Briefly describe why you are making this referral at this time:

Does this student need to be seen immediately (suicide risk, danger to others, etc.)? YES NO

If this is the case, do not hesitate to notify an administrator, counselor or school nurse.

PROBLEM AREAS (CHECK ANY OF THE FOLLOWING)

| School Performance | Behavior | Emotional | Social |
|--|--|---|---|
| <input type="checkbox"/> doesn't complete assignments | <input type="checkbox"/> argumentative | <input type="checkbox"/> sad | <input type="checkbox"/> doesn't get along with peers |
| <input type="checkbox"/> lacks motivation/uninterested in school | <input type="checkbox"/> low frustration | <input type="checkbox"/> anxious/nervous | <input type="checkbox"/> teased/disliked by peers |
| <input type="checkbox"/> frequent tardiness | <input type="checkbox"/> defiant | <input type="checkbox"/> irritable/angry | <input type="checkbox"/> prefers younger children |
| <input type="checkbox"/> poor attendance | <input type="checkbox"/> substance abuse | <input type="checkbox"/> feels worthless | <input type="checkbox"/> isolated/withdrawn |
| <input type="checkbox"/> short attention span | <input type="checkbox"/> not using toilet | <input type="checkbox"/> feels unloved | <input type="checkbox"/> suspected gang involvement |
| <input type="checkbox"/> moves constantly | <input type="checkbox"/> aggressive | <input type="checkbox"/> mood swings | <input type="checkbox"/> negative leader |
| <input type="checkbox"/> leaves class/school | <input type="checkbox"/> steals | <input type="checkbox"/> outbursts | |
| | <input type="checkbox"/> self-harm | | |
| Trauma/Loss | Medical/Physical | Modification(s) tried: | |
| <input type="checkbox"/> victim of violence | <input type="checkbox"/> poor hygiene | <input type="checkbox"/> small work group | <input type="checkbox"/> has 504 Plan |
| <input type="checkbox"/> witness to violence | <input type="checkbox"/> has vision needs | <input type="checkbox"/> behavior contract | <input type="checkbox"/> has IEP |
| <input type="checkbox"/> traumatic experience | <input type="checkbox"/> has hearing needs | <input type="checkbox"/> simple assignments | |
| <input type="checkbox"/> death/injury of family member/friend | <input type="checkbox"/> has dental needs | <input type="checkbox"/> SST Referral | |
| <input type="checkbox"/> police report made | <input type="checkbox"/> appears tired | <input type="checkbox"/> referral to office | |
| <input type="checkbox"/> other: _____ | <input type="checkbox"/> frequent trips to nurse | <input type="checkbox"/> change of seat | |
| | <input type="checkbox"/> under / over weight | <input type="checkbox"/> peer helper | |
| | | <input type="checkbox"/> parent/caregiver contact | |

Please notify Parent/Caregiver prior to submitting form.

Parent has been notified by person making referral Yes

Submit referral by fax to (626) 791-6251 or by district mail to: Burbank – Mental Health – Manager

| | | | |
|---------------------------------|----------------------|----------------------------------|---|
| MH OFFICE STAFF USE ONLY | Date received: _____ | Processed by: _____ | Date entered in EHR: _____ |
| Active MediCal (Y/N)? _____ | OHC (Y/N): _____ | SOC (Y/N): _____ | MC aid code: _____ IEP (Circle one): YES NO |
| Open DMH episode (Y/N)? _____ | Agency: _____ | Prior DMH treatment (Y/N)? _____ | |

| | | | |
|------------------------------------|--------------------------------------|---|---------------------|
| MH CLINICAL STAFF USE ONLY | Supervisor assigning referral: _____ | | |
| Assigned to: _____ | Assignment date: _____ | Funding (Circle): MediCal PEI RRR ERICS | |
| Referral disposition (Circle one): | Intake completed | Declined services | Not able to contact |
| Other: _____ | | | |

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