CONFIDENTIAL

PASADENA UNIFIED SCHOOL DISTRICT
Mental Health Services - Referral Form

1520 N Raymond Ave, Bldg 2-7, Pasadena CA 91103 - 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: ☐ School Psychologist ☐ Teacher ☐ School Administrator ☐ Nurse ☐ Parent ☐ Legal Guardian ☐ 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 yes, notify school administrator and/or call the PUSD Mental Health Services office at (626) 396-5920

PROBLEM AREAS *(CHECK ANY OF THE FOLLOWING)*

School Performance
- ☐ doesn't complete assignments
- ☐ lacks motivation/uninterested in school
- ☐ frequent tardiness
- ☐ poor attendance
- ☐ short attention span
- ☐ moves constantly
- ☐ leaves class/school

Behavior
- ☐ argumentative
- ☐ low frustration
- ☐ defiant
- ☐ substance abuse
- ☐ not using toilet
- ☐ aggressive
- ☐ steals
- ☐ self-harm

Emotional
- ☐ sad
- ☐ anxious/nervous
- ☐ irritable/angry
- ☐ feels worthless
- ☐ feels unloved
- ☐ mood swings
- ☐ outbursts

Social
- ☐ doesn't get along with peers
- ☐ teased/disliked by peers
- ☐ prefers younger children
- ☐ isolated/withdrawn
- ☐ suspected gang involvement
- ☐ negative leader

Trauma/Loss
- ☐ victim of violence
- ☐ witness to violence
- ☐ traumatic experience
- ☐ death/injury of family member/friend
- ☐ police report made
- ☐ other: _____

Medical/Physical
- ☐ poor hygiene
- ☐ has vision needs
- ☐ has hearing needs
- ☐ has dental needs
- ☐ appears tired
- ☐ frequent trips to nurse
- ☐ under / over weight

Modification(s) tried:
- ☐ small work group
- ☐ behavior contract
- ☐ simple assignments
- ☐ SST Referral
- ☐ referral to office
- ☐ change of seat
- ☐ peer helper
- ☐ parent/caregiver contact
- ☐ has 504 Plan
- ☐ has IEP

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: Washington CC – 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:** _____