



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 isolated/withdrawn 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

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