



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

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 isolated/withdrawn 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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