Pomona Unified School District
SCHOOL Mental Health SERVICES

School-Based

Date Received: ____________

SCHOOL MENTAL HEALTH REFERRAL FORM

Confidential

Return this form to the Program Administrator, School Mental Health Services

FAX: 909-623-9560

Name: ______________________________ **Date Referred:** ____________

School: ______________________________ **Grade:** ______ **DOB:** ___________

MEDICAL INSURANCE (*PLEASE ATTACH A COPY OF THE INSURANCE CARD)***:**

☐ MEDI-CAL* OR ☐ EMERGENCY MEDI-CAL   MEDI-CAL NUMBER: ____________________________

☐ PRIVATE INSURANCE (NAME): ____________________________________   ☐ NON-INSURED

☐ OTHER:____

Is this a crisis?	☐ Yes	☐ No
Self-Harm	☐ Yes	☐ No
Harm to others	☐ Yes	☐ No

REFERRED BY: ____

Is this student taking any medications? ☐ ***Yes*** ☐ ***No if yes, please list:***

____

____

Behavior or Reason of Concern:

____

____

____

____

____

Please List the Attempted Interventions by School Staff and/or Parent:

____

____

Please List Other Agencies/Programs involved with this student/and or family:

____

____

Has Parent been contacted regarding these concerns? ☐ **Yes** ☐ **No**

Social Interactions

- ☐ Social withdrawal/isolation
- ☐ Victim of bullying
- ☐ Recent changes in peer group
- ☐ No friends or difficulty making/keeping friends
- ☐ Affiliation with gangs
- ☐ Family conflict
- ☐ Patterns of impulsivity
- ☐ History of violent and aggressive behaviors
- ☐ Sexual acting out or promiscuity
- ☐ Sexual inappropriateness
- ☐ Bullying Others

Feelings/Thoughts

- ☐ Feelings of isolation/being alone
- ☐ Feelings of rejection
- ☐ Feelings of being picked on and persecuted
- ☐ Uncontrolled anger
- ☐ Persistent sadness
- ☐ Fearful/Anxious and/or Worried
- ☐ Feeling negative about Self
- ☐ Obsessive or compulsive thoughts
- ☐ Feeling worthless or inferior
- ☐ Feeling unmotivated

Other: ______________________

Behaviors

- ☐ Poor academic performance
- ☐ Low school interest
- ☐ Sudden changes in school attendance
- ☐ Lack of interest in things he/she used to enjoy
- ☐ Little to no affect displayed
- ☐ Hyperactive
- ☐ Stealing from others
- ☐ Frequent lying
- ☐ Running away from home
- ☐ History of discipline problems (suspensions, expulsions)
- ☐ Express violence in writing or drawings
- ☐ Preoccupation with death
- ☐ Animal abuse
- ☐ Access to, possession of and use of weapons away from school

Physical concerns/Symptoms

- ☐ Good general health
- ☐ Frequent complaints about physical aches and pains
- ☐ Unaccounted weight loss or gain
- ☐ Disordered eating
- ☐ Sleep disturbances/nightmares
- ☐ Wetting/soiling self at school
- ☐ Lack of attention to hygiene, grooming
- ☐ Drug use and/or alcohol use
- ☐ Sees or hears things that are not present
- ☐ Altered perception of time, space etc

Other:

- ☐ Victim of physical, emotional, sexual abuse or neglect

Special Education

- ☐ Has an IEP - Handicapping Condition: ____
- ☐ In the process of assessment

For the following area, please indicate your source of information i.e., student, parent or guardian: ____

Home Environment

- ☐ Unstable living arrangements
- ☐ Cares for siblings
- ☐ Problems with siblings
- ☐ Death of significant other (family, friend)
- ☐ Discipline concerns
- ☐ Addition to the family
- ☐ Changes in home environment (separation, divorce, homeless, incarceration of a family member, domestic violence etc.)
- ☐ Not living with biological family
- ☐ Other: ____

Parent/Guardian Name:__________________________________ **Home Language:** ___________________________

Current Contact Number(s): ____

Best Time to Call: __________________________________

Office: (909) 397-4491, ext 26501
Fax: (909) 623-9560

REFERRAL FORM

Name of Client: ______________________________________ **Date Referred:** ________________

School: ______________________________________ **Age:** _________ **DOB:** _________________

Medical Insurance: ☐ Private Insurance: ___________________________ ☐ Non-Insured
Name of Insurance

☐ **Medi-Cal*** or ☐ Emergency Medi-Cal **Medi-Cal Number:** __________________
Please attach a copy of Medi-Cal card to this referral

Name of Parent/Guardian ____

Street Address: __________________________________ **City:** _____________________ **Zip:** __________

Phone Number: _____________________________ **Alternate Number:** ____________________________

Best Time to Call: _____**AM or** ____**PM** **Home Language:** ______________________________

Child lives with: ☐ Parent ☐ Foster Parent ☐ Other: ________________________________

Has parent been contacted regarding these concerns? ☐ Yes ☐ No

Reason for referral: ____

____

____

____

Services recommended: ____

____

List services received or agencies involved with: ____

____

Referred By: ______________________________ **Phone:** _________________________

For FS & RC use only:
Referral Received by: ____________________________________ Date: ______________
Referral Assigned to: ____________________________________ Date: ______________

9/15

POMONA UNIFIED SCHOOL DISTRICT
SCHOOL MENTAL HEALTH SERVICES

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Please Type/Print All Information

Student's Name: ________________________________ Birth Date: ____________________

Mother's Name: ________________________________ Father's Name: ____________________

Home Address: ____________________________ City: __________________ Zip: ____________

I authorize a representative from Pomona Unified School District, School Mental Health Services to exchange information with ____ (Agency/Person/Organization) and/or those listed below regarding my child. I hereby authorize the release of all pertinent records, documents, and information on my child and/or family.

The following agencies also share a partnership with the School Mental Health Services Department and are authorized to share information:

- ☐ Department of Children and Family Services
- ☐ Law Enforcement
- ☐ Pomona Unified School District Personnel
- ☐ Tri-City Mental Health Center
- ☐ The David & Margaret Home
- ☐ Crittenton
- ☐ Probation Department
- ☐ Ettie Lee
- ☐ Public Health Department
- ☐ Pacific Clinics
- ☐ Leroy Haynes
- ☐ Other: ____________________________

I understand that the purpose of exchanging information among the agencies is to develop and implement an intervention plan that will best support your child and/or family.

I also understand this authorization will be in effect for the duration of the services provided to my child(ren) and/or family and will expire upon the termination of services or I can revoke this consent at any time.

I certify I have read this consent carefully and understand this form.

Date: __________________

Signed (Parent, Guardian): _________________________________

Print Name: _____________________________ Relationship: ____________________________

DISTRITO ESCOLAR UNIFICADO DE POMONA
SERVICIOS DE SALUD MENTAL ESCOLAR

CONSENTIMIENTO PARA DAR INFORMACIÓN CONFIDENCIAL

Favor De Escribir Toda La Informacion

Nombre del Estudiante: ______________________________ Fecha de Nacimiento: ____________________

Nombre de la Madre/Tutor: ______________________________ Nombre de la Padre/Tutor: ____________________

Dirección: ____________________________ Ciudad: ______________ Código: ___________

Yo autorizo al representante del Distrito Escolar Unificado de Pomona, Servicios de Salud Mental Escolar poder intercambiar información acerca de mi niño/a con la (Agencia, Persona, Organizacion) ____________________________________ y/o ésos de la lista siguiente.
Yo doy autorización para que den todo lo pertinente del archivo, documentos e información relacionados a mi niño/a y/o a mi familia.

Las siguientes agencias también tienen una asociacion con el Departamento de Salud Mental Escolar y están autorizados para compartir información:

- ☐ Pomona Unified School District Personnel
- ☐ Department of Children and Family Services
- ☐ Law Enforcement
- ☐ Tri-City Mental Health Center
- ☐ The David & Margaret Home
- ☐ Crittenton
- ☐ Probation Department
- ☐ Ettie Lee
- ☐ Masada Homes
- ☐ Pacific Clinics
- ☐ Haynes Family of Services
- ☐ Other: __________________________

Yo entiendo que el propósito de intercambiar esta información entre estas agencias es para desarrollar y implementer un plan de intervención que ayudará a mi niño/a y/o familia.

Yo entiendo también que esta autorización estará en efecto mientras que servicios sean proveeídos a mi niño/a (os/as) y/o familia y se vence cuando estos sevicios se terminen o yo puedo revocar este consentimiento a cualquier tiempo.

Yo certifico que he leído este consentimiento y entiendo esta forma.

Fecha: _________________

Firma (Padre/Madre, Tutor): ____

Nombre: ______________________________ Relación: ______________________________