MENTAL HEALTH SUPPORT REFERRAL FORM
OAK GROVE SCHOOL DISTRICT
Referral goes to: Kristina Borrego – kborrego@ogsd.net
School Linked Services

Referring Source:	**Referring Person Email/Phone #:** ( )			**Date:**
PARTICIPANT INFORMATION				
Student Last Name:	**First:**	**Middle:**	**Primary Language :**	
Address:	**City/Zip:**	**Birthdate:**	**Age:**	**Sex:** ❑ M ❑ F
SS #:	**Medi-Cal Coverage:** YES or NO	**Medi-Cal #:**		
Medical Issues:			**Education Support:** 504 Plan IEP BIP NONE	
Current School:	**Grade:**	**School Contact Person #:** ( )		
Parent/Guardian:		**Phone #:** ( ) ( )	**Parent/Guardian Primary Language:**	
Student's Strengths/Interests:				
REASON FOR REFERRAL: School Concerns: Home Concerns:				

I consent to allow school personnel to refer my child (name) _____ for services provided by collaborating community agencies (i.e. Alum Rock Counseling Center, Community Solutions, Rebekah Children's Services, etc.). I understand that relevant information may be provided to appropriate community agencies, such as name, address, phone number, attendance records, discipline, and grades.

_____

Parent or Legal Guardian Signature Date:

SLS Coordinator Use Only:	**Agency Use Only:**
Date SLS Coordinator received referral: _____ **Required Documents:** **_ Grades** **_ Attendance Reports** **_ Disciplinary Report** **_ Other (SST Forms)** **SSID# _____**	**Date Agency received: _____** **Assigned to:** **_ Alum Rock Counseling Center** **_ Community Solutions** **_ Rebekah Children's Services** **_ Prevention & Early Intervention (PEI)** **_ OGSD Internal/MFT** **_ Other: _____** **_ Staff Assignment: Date:**

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