Manteca Unified School District
Department of Health Services

Valley Community Counseling Referral

Student Name: _____ Date: _____ School Site: _____
Rm #: _____ Teacher: _____ Grade: _____ Gender: _____
Student's Primary Language: _____ Parent's Primary Language: _____
Referral from: ☐ SST ☐ COST ☐ Parent ☐ Teacher ☐ Other: _____

Reason(s) for Referral:

☐ Suicidal Ideation	☐ Anxiety	☐ Depressed/Sad	☐ Other: _____
☐ Attendance	☐ Defiance	☐ Withdrawn	_____
☐ Peer Conflict	☐ Gender issues	☐ Foster/CSP	_____
☐ Family Concerns	☐ Abuse	☐ Behavior	_____
☐ Academics	☐ Suspensions	☐ Transitions	_____

Tier 1 & 2 Interventions Utilized:

☐ Parent meeting ☐ PBIS ☐ Differentiation of curriculum	☐ Clearly articulated classroom behavior ☐ Before/after school interventions	☐ SEL BASE or Harmony ☐ Check in/Check out ☐ All supports within the classroom

Goal or Expected Outcome: _____

_____

_____

How will we know the goal is met? _____

_____

_____

Number of sessions before reassessment: _____

Additional Comments: _____

_____

_____

Date referring party contacted parents: _____ Previous Counseling ☐ Yes ☐ No
Parent's Response: _____

_____

Referral submitted by: _____ Relationship to student: _____

311 E. North St., Manteca, Ca, 95336
www.mantecausd.net
Phone: (209) 858-0782
Fax: (209) 858-7513
Email: HealthServicesSupport@musd.net

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Follow Up:

To be completed by the VCC Counselor and reviewed with stie admin.

Student Name: _____ Date of Referral: _____ School Site: _____
Rm #: _____ Teacher: _____ Grade: _____ Gender: _____
Initial Referral Date: _____ Progress check date: _____
Number of sessions: _____

Was the goal met? ☐ Yes ☐ No;

If not met, was progress towards the goal made? ☐ Yes ☐ No

Evidence of progress made or goal met: _____
_____
_____

Plan:
☐ Goal unchanged; continue to see student.
☐ Goal modified; continue to see student.
☐ New goal identified; continue to see student.
☐ Goal met; new goal not identified; discontinue services.
☐ No progress toward goal, discontinue services.

New/modified goal: _____
_____
_____

Timeline for reassessment (number of sessions): _____

Plan and data have been reviewed with site admin: ☐ Yes ☐ No

If no, please provide reason: _____

*__Confidentiality:__ Confidential details of conversations with students are not required or requested to be shared via this document. Safety concerns should always be brought to the attention of the site administrator.

Completed forms can be scanned to HealthServicesSupport@musd.net

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