Fontana Unified School District

Referral to Therapeutic Counseling Services

Referring Person: ______________________ School Site: ______________

Contact information: ______________________ Date: ________

Student Name: ______________________ Grade: ________ Age: ______

Home Address: __________________________________ Date of Birth: ______

____

Student ID # __________ Student currently receives Special Education services? YES ☐ NO ☐

Parent/Guardian: ______________________ Language spoken: __________

Relationship to student: ______________________ Contact Number: __________

Should a referral to an outside provider be needed for the student, please provide the following applicable information:

Health Insurance Provider: ______________________ Social Security #: ______________

Behavioral Concerns (Check all that apply)

☐ Adjustment to life events	☐ Suicide risk	☐ Drug/Alcohol Use	☐ Feeling hopeless
☐ Grief and Loss	☐ Poor Concentration	☐ Self-harm behaviors	☐ Anxiety
☐ Bullying/Victim of Bully	☐ Poor hygiene	☐ Harm to others	☐ Anger outbursts
☐ Withdrawn/Isolating	☐ Depressed mood	☐ Suspension or expulsion	☐ Drop in grades
☐ Trouble sleeping	☐ Hallucinations	☐ Hospitalization- psychiatric	☐ Loss of employment
☐ Weight gain or loss	☐ Paranoia	☐ Property damage	☐ Trauma

Reason for Referral:

Please fax this referral form to the MTSS Department at 909-357-7531 .
All questions and follow-up inquiries can be directed to Liz Romanio, LMFT at ext 29265.

☐ Parent/Guardian notified of referral to services ☐ Therapeutic Counseling Notification form sent to parent/guardian