

THErapy REFERRAL FORM SCHOOL-BASED SERVICES

2025-26

COMPLETE TOP PORTION ONLY: * * * **Please include a Student Profile** * * *

Student's Name: _____ Date Referral Submitted: _____

DOB: _____ Age: _____ Gender: _____ Grade: _____

RM#: _____ Teacher: _____ Special ED: SDC RSP Speech Other: _____

Student's Primary Language: _____ Parent's Primary Language: _____

Student's Second Language: _____ Parent's Second Language: _____

REASONS FOR REFERRAL TO THERAPY: When were symptoms first noticed?

- | | | |
|---|---------------------------------|---------------------------------------|
| _____ frequent absences and tardiness | _____ anxious | _____ Foster care/ social services |
| _____ conflict with peers | _____ defiance | _____ crime/CPS report |
| _____ separation or divorce of parent's | _____ physical or sexual abuse | _____ disruptive behavior |
| _____ death of a family member/other | _____ verbal or emotional abuse | _____ anger |
| _____ fidgety, difficulty concentrating | _____ frequent suspensions | _____ self-injurious _____ |
| _____ doesn't complete/turn in work | _____ at risk of expulsion | _____ transitions (new school, recent |
| _____ family history of substance abuse | _____ depressed, sad, withdrawn | _____ move remarriage of parent) |
| _____ suicidal ideation/ plan /attempt | | Other: _____ |

COMMENTS:

Student's Behavior: _____

Family History: _____

Date Teacher or counselor contacted Parents: _____ Previous Counseling: Yes No Unsure

Parent's Response/Outcome: _____

Referral submitted by: _____ Relationship to Student: _____

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Parent 1: _____ Relation: _____ **Date Referral**

Parent 2: _____ Relation: _____ **Received:** _____

Caretaker: _____ Specify: stepparent / legal guardian / other: _____

Address: _____ City _____ ZIP _____

Home () _____ Cell () _____ email: _____

Date Medi-Cal verified w/VCCS staff: _____ CMH Opened Yes No If opened date: _____

Medi-CAL – County Code: _____ Full Scope: Yes No _____

Health Insurance: _____ Secondary: Yes / No
 vccs staff

VCCS Staff: _____ Date: _____ Copy to: referring party

INITIAL CONTACT: _____ Student's Name: _____

NOTES:

OUTCOME: Lack of response Declined Service Waiting List for: _____
 Already receiving services: specify: _____

Request = parent/guardian verbally agrees to assessment

	<i>Date</i>	<i>Time</i>	<i>Status of appt (s, n/s, C r/s, T r/s, CC)</i>
Initial Request			
First Offered (available appt)			
Second Offered (available appt)			
Third Offered (available appt)			
First Accepted (scheduled appt)			<input type="checkbox"/> Fax to Liz
NOABD: Timely Access	<input type="checkbox"/> NOABD ltr/Rights		
2 nd Appt Scheduled			<input type="checkbox"/> Fax to Liz
3 rd Appt Scheduled			<input type="checkbox"/> Fax to Liz
First Kept (Opening)			
Assessment Date			<i>Date completed:</i>
First offered Txt Appt			<input type="checkbox"/> Fax to Liz
Second offered Txt Appt			
Third offered Txt Appt			
First Kept Txt Appt			<input type="checkbox"/> Fax to Liz

NOABD (Med Nec) Delivery System Notice: NOABD ltr/Rights Beacon Ref Health Net Ref
 Beacon Bi-directional Ref (mild to mod)-transitioning to lower level of care

DIRECT TO: Mental Health: (circle one) EPSDT / Clinic / CYS(SJBHS) CARES

VCCS: VCB CHAT School Funded Other: _____

NOTES:

Print Staff Name: _____