Interface Mental Health Services School Referral Form

Referral Date: _____

Referral/Screening Source

Referring Person: _____ Relation to client: _____

Phone: _____ Email: _____

School Information

School District: _____ Teacher's Name: _____

Phone: _____

School Name: ❑ _____ Elementary

❒ _____ Jr. High Grade: _____

❒ _____ High School

Client Information

Last name: _____ First name:_____ MI:____

Primary Language: ❑English ❑Spanish ❑Other:_____ Date of Birth:_____

Parent or Caregiver info: Name:_____ Relationship to client:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Do we have permission to leave a msg? Yes ☐ No ☐

Address: _____

City: _____ Zip: _____

Current Services: ❑Probation ❑Drug and Alcohol ❑Special Education ❑Public Health ❑Wrap ❑TBS ❑Regional Center ❑CFS: Worker's Name/Number:_____

Insurance Status: ❑Medi-Cal #_____ Issue Date: _____

❑ None ❑ Private or other insurance ❑ Unknown

Presenting Problem/Background:_____

_____

_____

_____

_____

_____

History

1. Family History of: ❑Mental disorder ❑Incarceration ❑Substance abuse ❑Domestic violence

2. Experienced/witnessed abuse, violence, trauma, or neglect? ❑Yes ❑No ❑Unknown

❑Sex Abuse (❑witness ❑victim) ❑Neglect (❑witness ❑victim) ❑Physical Abuse (❑witness ❑victim) ❑Trauma (❑witness ❑victim)

3. Significant exposure to teratogens (alcohol, drugs, lead, etc.)? ❑Yes ❑No ❑Unknown

4. History of mental health treatment/intervention? ❑Yes ❑No ❑Unknown

❑Psychiatric hospitalization ❑Therapy ❑School counseling ❑Residential

❑Psychiatric meds:_____

Urgent & Emergency Questions

1. Danger to self or others in the last 30 days? ❑Yes ❑No ❑Unknown
If Yes, please describe: _____

2. Bizarre/unusual behavior in the last 30 days? ❑Yes ❑No ❑Unknown
If Yes, please describe: _____

Routine Questions

1. Social adjustment problems? ☐Yes ☐No ☐Unknown

☐Damages own/others property ☐Runs away ☐Lack of guilt ☐Steals ☐Fights ☐Mute

2. Difficulty managing emotions? ☐Yes ☐No ☐Unknown

☐Severe temper tantrums ☐Nightmares ☐Overactive ☐Cries inconsolably
☐Feels hopeless ☐Sad/withdrawn ☐Feels worthless ☐Excess worry

3. Problems making and maintaining healthy relationships? ☐Yes ☐No ☐Unknown

☐Poor peer relationships ☐Poor bond with caregiver ☐Gang involved ☐Provokes & victimizes

4. Personal care problems? ☐Yes ☐No ☐Unknown

☐Frequently wets or soils self ☐Eats/drinks things that aren't food ☐Poor hygiene

5. Significant functional or daily living problems? ☐Yes ☐No ☐Unknown

☐Significant language delays ☐Can't manage age appropriate skills
☐Difficulty sleeping ☐Difficulty understanding others

6. Child of parental abuse or alcohol and/or drugs? ☐Yes ☐No ☐Unknown

☐Meth/Stimulants ☐Cannabis ☐Alcohol Other:

Additional Questions

1. Is the child in any special education, resource classes or receiving special assistance through the school?
_____

2. *Does the child have an IEP?* ☐Yes ☐No ☐Unknown
Or is one scheduled? ☐Yes ☐No ☐Unknown - If so when? _____

❑*English Statement*
I understand that my child is being referred to Interface Children & Family Services for mental health services. I understand that my participation with my child is essential. I hereby give my consent for the exchange and release of information for this purpose.

❑*Spanish Statement*
Entiendo que mi niño está siendo referido al Interface Children & Family Services para servicios de Salud Mental. Entiendo que mi participación con mi niño es esencial. Doy por este medio mi consentimiento para el intercambio y el lanzamiento de información para este propósito.

_____
Authorized Signature (Parent or Guardian) Date

Complete and fax to: Interface Mental Health Services Intake Dept. 805-278-4391
Questions: Contact Intake Dept. 805-485-6114 ext. 662