Interface Mental Health ServicesReferral Form
School Referral

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: _____________________

Insurance Status: ❑Medi-Cal #______________________________ Issue Date: ___________________________
❑ None ❑ Private or other insurance ❑ Unknown

Presenting Problem/Background:____
____
____
____
____
____
____
____

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: ______
3. *Experienced/witnessed abuse, violence, trauma, or neglect?* ❑Yes ❑No ❑Unknown
   If Yes, please describe: ______

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