Los Angeles Unified School District
STUDENT HEALTH AND HUMAN SERVICES
SCHOOL MENTAL HEALTH

SMH Referral Cover Sheet

Parent Referral Form

DATE:_____

From: _____
Name/Title of Person Submitting Referral

Email address: _____

Telephone Number(s): _____

Please select one location:

- **North**
  - ☐ Valley Clinic | 6651 Balboa Blvd Van Nuys, California 91406 | Tel: 818-758-2300 | Fax 818-996-9850
    Please indicate if you would like to be considered for services at a Valley Clinic Satellite Location:
    ☐ Kennedy HS (Granada Hills) ☐ Telfair ES (Pacoima) ☐ Canoga Park ES (Canoga Park)

- **West**
  - ☐ Crenshaw Wellness Center | 3206 W. 50th St., Los Angeles, 90043 | Tel: 323-290-7737 | Fax: 323-290-7713
    Please indicate if you would like to be considered for services at our Crenshaw Wellness Center Satellite location at
    ☐ YES Academy (3140 Hyde Park Blvd., Los Angeles, 90043)
  - ☐ Washington Wellness Center | 1555 West 110th St., Los Angeles, 90043 | Tel: 323-241-1909 | Fax: 323-241-1918

- **South**
  - ☐ San Pedro Clinic | 704 West 8th St., San Pedro, 90731 | Tel: 310-832-7545 | Fax: 310-833-8580
  - ☐ Locke Wellness Center | 316 111th St., Los Angeles, CA 90061 | Tel: 323-418-1055 | Fax: 323-418-3964
  - ☐ 97th St. Clinic | 439 W. 97th St., Los Angeles, CA, 90003 | Tel: 323-754-2856 | Fax: 323-754-1843
  - ☐ Carson Wellness Center | 270 East 223rd St., Carson, 90745 | Tel: 310-847-7216 | Fax: 310-847-7214

- **East**
  - ☐ Ramona Clinic | 231 S. Alma Ave, Los Angeles, 90063 | Tel: 323-266-7615 | Fax: 323-266-7695
  - ☐ Gage Wellness Center | 2975 Zoe Ave., Huntington Park, 90255 | Tel: 323-826-1520 | Fax: 323-826-1524
  - ☐ Elizabeth LC Wellness Center | 4811 Elizabeth St., Cudahy, 90201 | Tel: 323-271-3650 | Fax: 323-271-3657
  - ☐ Bell Clinic | 7326 S. Wilcox Ave., Cudahy, 90201 | Tel: 323-869-1352 | Fax: 323-271-3657
  - ☐ Maywood Wellness Center | 5800 King Ave., Maywood, 90270 | Tel: 323-826-1520 | Fax: 323-826-1524

- **Central**
  - ☐ Belmont Wellness Center | 180 Union Place, Los Angeles, 90026 | Tel: 213-241-4451 | Fax: 213-241-4465
    Please indicate if you would like to be considered for services at one of these Clinic Satellite Locations:
    ☐ Wadsworth ES (981 E. 41st St., Los Angeles, 90011) ☐ Marshall SH (3939 Tracy St, Los Angeles, 90027)
    ☐ Glassell Park ES (2211 W. Ave. 30, Los Angeles, 90065)
  - ☐ Roybal Clinic | 1200 West Colton St., Los Angeles, 90026 | Tel: 213-580-6415 | Fax: 213-241-4465

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SCHOOL MENTAL HEALTH

STUDENT IDENTIFYING INFORMATION:

Date: _____ Student Name_____ DOB: _____ School: _____ Grade_____

Who referred you to School Mental Health? Name:_____ School/Organization:_____

Who does your child live with? ☐ Biological Parents ☐ Adoptive Parents ☐ Foster Parents

☐ Relative Care ☐ Group Home ☐ Other: _____

Name of Parent/Caregiver 1: _____ Relationship: _____

Telephone Parent/Guardian 1: home: _____ cell: _____ work: _____

Name of Parent/Caregiver 2: _____ Relationship: _____

Telephone Parent/Guardian 1: home: _____ cell: _____ work: _____

Home Address: _____Is family homeless?: ☐ Yes ☐ No

Desired Language of Service: ☐ English ☐ Spanish ☐ Other _____

Does your child have an IEP?: ☐ Yes ☐ No

Type of Health Coverage: ☐ Medi-Cal ☐ Private ☐ Don't Know ☐ Other _____

Please check all that apply	
Trauma Exposed Behaviors	**Disruptive Behaviors**
☐ Exposed to community violence, other trauma	☐ Talks excessively
☐ Nightmares, intrusive thoughts	☐ Gets out of seat and moves constantly
☐ Anxious, fearful or irritable mood	☐ Interrupts and blurts out responses
☐ Jumpy or easily startled	☐ Inattentive, distractible, forgetful
☐ Avoids reminders of trauma	☐ Disorganized, makes careless mistakes
☐ Aggressive	☐ Angry towards others, blames others
☐ Sexualized play or behaviors	☐ Fights and is aggressive
☐ Difficulty concentrating	☐ Argumentative and defiant
Depressive Behaviors	**Anxious Behaviors**
☐ Sad, depressed or irritable mood	☐ Anxious and fearful
☐ Hopelessness, negative view of future	☐ Worries excessively
☐ Low self esteem, negative self statements	☐ Difficulty sleeping
☐ Self-injurious behaviors and/or thoughts	☐ Restless and on edge
☐ Changes in sleep and/or appetite	☐ Specific fears or phobias
☐ Difficulty concentrating	☐ Difficulty concentrating
☐ Diminished interest in activities	☐ Clingy behavior
☐ Low or decreased motivation	☐ Appears distracted

Additional comments regarding your child's behaviors or symptoms.

Please share any significant academic, social, and/or family information.

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Parent/Guardian Acknowledgment Form

Date:_____

By signing, I agree to allow an LAUSD SMH employee to contact my child's school for information pertaining to this referral.

Parent or Legal Guardian Signature_____

Address _____

Telephone Number _____ Cell Phone _____

Formulario de autorización del padre/tutor

Fecha: _____

Al firmar, doy mi autorización para que un empleado de la oficina SMH del LAUSD se comunique con la escuela de mi hijo en relación con la información relacionada con esta remisión.

Firma del padre o tutor Legal _____

Dirección _____

Número de teléfono _____ Teléfono celular _____