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

# SMH Referral Cover Sheet

School/Community Referral

**DATE**:_____

**From:** _____
Name/Title

**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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**Please complete this referral thoroughly. An incomplete referral may delay services.**

## STUDENT IDENTIFYING INFORMATION:

Name: _____ DOB: _____ School: _____ Student ID#: _____

Referring Person: _____ Position: _____ Phone Number: _____

Student resides with: ☐ Parent(s) ☐ Adoptive Parent(s) ☐ Foster Parent(s) ☐ Other: _____

Name of Parent/Caregiver 1:_____ Name of Parent/Caregiver 2:_____

Home Address: _____ Is family homeless?: ☐ Yes ☐ No

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

Parent/Guardian 2: home telephone: _____ cell: _____ work: _____

Language(s) spoken at home: ☐ English ☐ Spanish ☐ Other_____ Does the student have an IEP? ☐ Yes ☐ No

Are the student's caretakers members of the US Military?: 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 |
| ***Have you completed a RARD?*** ☐ **No** ☐ **Yes, date:_____** | ☐ Specific fears or phobias |
| ☐ Changes in sleep and/or appetite | ☐ Difficulty concentrating |
| ☐ Difficulty concentrating | ☐ Clingy behavior |
| ☐ Diminished interest in activities | ☐ Appears distracted |
| ☐ Low or decreased motivation | |

***For immediate concerns about danger to self or others, please contact LA County DMH ACCESS 800-854-7771***

***All LAUSD employees are mandated to report suspected child abuse.***

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| Additional comments regarding the student's behaviors or symptoms. |
| --- |
| |
| **Please share any significant academic, social, and/or family information.** |
| |
| **Please identify any other referrals you are making for this student at this time.** |
| |

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# Parent/Guardian Acknowledgment Form

Date:_____

I acknowledge that school personnel at _____ School are referring my child to receive mental health services by LAUSD School Mental Health (SMH).

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 _____

Yo reconozco que el personal de la escuela _____ esta recomendando a mi hijo(a) para recibir servicios de salud mental por medio de la Clinica de Salud Mental del Distrito Escolar Unificado de Los Angeles.

Mi firma esta autorizando que un empleado de la Clinica de Salud Mental del Distrito Unificado de Los Angeles (LAUSD) se comunique con la escuela de mi hijo para obtener informacion relacionada a esta recomendación.

Firma del Padre o Tutor _____ Domicilio _____

Numero de telefono _____ Telefono Celular _____

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