Los Angeles Unified School District
STUDENT HEALTH AND HUMAN SERVICES

SCHOOL MENTAL HEALTH CLINIC REFERRAL

Referral Cover Sheet

Date: _____

Name of Person Completing Referral: _____

Are you a (Check one): ☐ **Parent/Legal Guardian** ☐ **Student** ☐ **School/District Staff**

Title (School/District Staff Only): _____

Email Address (if student, use District-issued email): _____

Clinic Hours are Monday-Friday 8am-4:30pm

Please submit the completed referral to the family's preferred location:

97th St. Clinic: smh.97@lausd.net	(323) 754-2856	Fax (323) 754-1843
Balboa Student & Family W.C: smh.valley@lausd.net	(818) 758-2300	Fax (818) 996-9850
Belmont Wellness Center: smh.belmont@lausd.net	(213) 241-4451	Fax (213) 241-4465
Carson Wellness Center: smh.carson@lausd.net	(310) 847-7216	Fax (310) 837-7214
Crenshaw Wellness Center: smh.crenshaw@lausd.net	(323) 290-7737	Fax (323) 241-1918
Drew Student and Family WC: smh.drew@lausd.net	(213) 460-6766	Fax (323) 587-3135
Elizabeth Wellness Center: smh.elc@lausd.net	(323) 271-3650	Fax (323) 271-3657
Gage Wellness Center: smh.gage@lausd.net	(323) 826-1520	Fax (323) 826-1524
Locke Wellness Center: smh.locke@lausd.net	(323) 418-1055	Fax (323) 418-3964
Maclay Student and Family W.C: smh.maclay@lausd.net	(818) 794-5280	Fax (818) 794-2580
Ramona Clinic: smh.ramona@lausd.net	(323) 266-7615	Fax (323) 266-7695
San Pedro Clinic: smh.sanpedro@lausd.net	(310) 832-7545	Fax (310) 833-8580
Washington Wellness Center: smh.washington@lausd.net	(323) 241-1909	Fax (323) 241-1918
YES Student & Family Wellness Center smh.yes@lausd.net	(213) 684-6500	Fax (323) 778-7804

Information for the referent: Services provided can be in-person or virtual during office hours.

Please complete this referral thoroughly. Incomplete referrals will be returned for completion.
Referrals will be processed within 48 hours of receipt.

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STUDENT INFORMATION

Student Name: _____ **Student's Affirmed Name:** _____

Student ID: _____ **DOB:** _____ **Gender:** _____

School: _____ **Grade:** _____

Student resides with: ☐ **Parent(s)** ☐ **Foster Parent(s)** ☐ **Legal Guardian** ☐ **Other:** _____

PARENT/LEGAL GUARDIAN

Name: _____ **Relationship:** ☐ **Parent** ☐ **Legal Guardian** ☐ **Caregiver**

Contact: _____ _____ _____
Home Telephone **Cell Phone** **Work Phone**

Current Address: _____
Number/Street Name, Apartment, City State, Zip Code

Email: _____ **Is your family experiencing housing insecurity?** ☐ **YES** ☐ **NO** ☐ **UNKNOWN**

Language(s) spoken at home: ☐ **English** ☐ **Spanish** ☐ **Other** _____

Student's preferred language: _____

HEALTH CARE PROVIDER & SERVICE TYPE:

Health Coverage: ☐ Medi-Cal # _____ ☐ Private ☐ Uninsured ☐ Unknown

☐ Other: _____

Currently receiving outpatient mental health services? ☐ YES _____ ☐ NO ☐ Unknown
Name of Mental Health Agency

Service Type Preference:

☐ In-Person

☐ Telehealth
Does the family have access to telehealth technology? ☐ Yes ☐ No

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REFERRAL REASON(S)

- ☐ Difficulty concentrating/easily distracted
- ☐ Sleeping/eating disturbance
- ☐ Aggressive behaviors
- ☐ Symptoms of psychosis (e.g., hearing voices, visual hallucinations, delusional beliefs)
- ☐ Exposure to trauma
- ☐ Decreased interest in activities/withdrawn/isolated
- ☐ Low mood/feelings of hopelessness/worthlessness
- ☐ Excessive worry/nervous/anxious
- ☐ Substance use/abuse
- ☐ Excessive absences/school refusal
- ☐ Grief/loss (explain situation below)

HIGH RISK INDICATORS (Check all that apply.)

- ☐ Danger to self/suicidal ideation/self-injurious behaviors
- ☐ Danger to others
- ☐ Recent 5150/5585 (transport for psychiatric evaluation) or psychiatric hospitalization (provide facility name & time period below)
- ☐ Risk assessment conducted Date:_____ Risk level:_____
  Date:_____ Risk level:_____
- ☐ Safety Plan completed (please attach)
- ☐ Parent/caregiver provided appropriate BUL-2637 and/or BUL-5799 parent/caregiver handouts and a copy of safety plan
- ☐ Not Applicable

ADDITIONAL INFORMATION

For immediate concerns about danger to self or others,
contact LA County DMH ACCESS (800) 854-7771 or LASPD (213) 625-6631.
As a reminder, all LAUSD employees are mandated to report suspected child abuse to the appropriate child protective services agency, as well as threats or perceived threats to commit a homicidal act to law enforcement.

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Parent/Guardian Acknowledgment Form
Formulario de Consentimiento del Padre, Madre o Tutor
(Wet or Electronic signature is required/Se debe firmar en persona o electrónicamente)

Date/Fecha: _____

I acknowledge that school/community agency personnel at _____ are referring my child
(**Name of School or Community Agency)**
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 that may include academic, behavior, and attendance information.

Parent or Legal Guardian Signature_____

Address _____

Telephone Number _____ **Cell Phone** _____

I am available on _____ at _____ ☐ **AM** ☐ **PM**.

Yo otorgo mi consentimiento para que el personal de la escuela/agencia comunitaria _____
(**Nombre de la Escuela o Agencia Comunitaria)**
remita a mi hijo(a) para recibir servicios de salud mental por medio de la Clinica de Salud Mental del Distrito Escolar Unificado de Los Ángeles.

Mi firma autoriza que un empleado de la Clinica de Salud Mental del Distrito Unificado de Los Ángeles (LAUSD) se comunique con la escuela de mi hijo para obtener información relacionada a esta remisión, la cual puede incluir información académica, conductual y de asistencia.

Firma del Padre, Madre o Tutor _____

Domicilio _____

Numero de telefono _____ **Telefono Celular** _____

Estoy disponible de las _____ **a las** _____ ☐ **AM** ☐ **PM**.

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California law requires that parent/guardian consent be obtained for all minors seeking mental health services, with limited exceptions.

Please check one of the following:

☐ I am under 18 years of age. Please contact my parent/guardian to schedule an intake appointment.

☐ I am under 18 years old and do not want my parent/guardian to be notified of this referral.

Please contact me at _____.

☐ I am 18 years or older and would like to have my parent/guardian contacted to schedule an intake appointment.

☐ I am 18 years or older and am not conserved or under guardianship. I DO NOT want my parents contacted regarding this referral.

Please contact me at _____ to schedule an intake appointment.

I am available on _____ at _____ ☐ AM ☐ PM.

Note: *a therapist will meet with you one time to determine if you can receive services without the consent of your parent/guardian, in accordance with applicable law. If we are unable to provide the service without their consent, the therapist will discuss your options with you.*

Printed Name: _____

Signature: _____ **Date** _____

La ley de California requiere que se obtenga consentimiento de los padres/tutores para todos los menores que buscan servicios de salud mental, con excepciones limitadas.

Por favor marque uno de los siguientes:

☐ Soy menor de 18 años. Comuníquese con mi padre/tutor para programar una cita de admisión.

☐ Soy menor de 18 años y no quiero que mi padre/tutor sea notificado de esta referencia.

Por favor, póngase en contacto conmigo en _____.

☐ Tengo 18 años o más y me gustaría que se comuniquen con mis padres/tutores para programar una cita de admisión.

☐ Tengo 18 años o más y no quiero que se comuniquen con mis padres con respecto a esta referencia.

Comuníquese conmigo al _____ para programar una cita de admisión.

Estoy disponible el _____ a las _____ ☐ AM ☐ PM.

Nota: *Un terapeuta se reunirá con usted una vez para determinar si puede recibir servicios legalmente sin el consentimiento de sus padres o tutores. Si no podemos proporcionar el servicio sin dicho consentimiento, el terapeuta analizará sus opciones con usted.*

Nombre Impreso: _____

Firma: _____ **Fecha:** _____