



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

Counseling Referral Cover Sheet
School/Community Referral

DATE: _____

From: _____ Email address: _____
Name/Title

Telephone Number(s): _____

Please indicate the family's preferred School Mental Health Clinic, Center or satellite location and submit completed referral via clinic email listed below:

➤ **North**

- Balboa Mental Health Center | 6651 Balboa Blvd Van Nuys, California 91406 | Email: smh.valley@lausd.net
 Columbus Health Center Maclay Wellness Center Panorama High School Kennedy Clinic Telfair Clinic

➤ **West**

- Crenshaw Wellness Center | 3206 W. 50th St., Los Angeles, 90043 | Email: smh.crenshaw@lausd.net
 YES Academy
 Washington Wellness Center | 1555 West 110th St., Los Angeles, 90047 | Email: smh.washington@lausd.net

➤ **South**

- San Pedro Support Center | 704 West 8th St., San Pedro, 90731 | Email: smh.sanpedro@lausd.net
 Wilmington Middle School
 Locke Wellness Center | 316 111th St., Los Angeles, CA 90061 | Email: smh.locke@lausd.net
 97th St. Support Center | 439 W. 97th St., Los Angeles, CA, 90003 | Email: smh.97@lausd.net
 Carson Wellness Center | 270 East 223rd St., Carson, 90745 | Email: smh.carson@lausd.net

➤ **East**

- Ramona Support Center | 231 S. Alma Ave, Los Angeles, 90063 | Email: smh.ramona@lausd.net
 El Sereno Middle School
 Gage Wellness Center | 2975 Zoe Ave., Huntington Park, 90255 | Email: smh.gage@lausd.net
 Holmes ES Middleton ES San Miguel Healthy Start Center
 Elizabeth LC Wellness Center | 4811 Elizabeth St., Cudahy, 90201 | Email: smh.elc@lausd.net
 Maywood Wellness Center located at Maywood Center for Enriched Studies
 Bell Support Center | 7326 S. Wilcox Ave., Cudahy, 90201 | Email: smh.bell@lausd.net

➤ **Central**

- Belmont Wellness Center | 180 Union Place, Los Angeles, 90026 | Email: smh.belmont@lausd.net
 Glassell Park Elementary School Marshall High School
 Roybal Support Center | 1200 West Colton St., Los Angeles, 90026 | Email: smh.roybal@lausd.net
 Hooper ES or Wadsworth ES (satellite locations)

If you have any questions about completing this referral, please call 213-241-3840; after choosing your language, choose option 3 to reach the Clinic and Wellness program.



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

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

STUDENT IDENTIFYING INFORMATION:

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

Referring Person: _____ Position/Role: _____ Phone Number: _____

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

Name of Parent/Caregiver 1: _____ Relationship: _____

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

Name of Parent/Caregiver 2: _____ Relationship: _____

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

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

Language(s) spoken at home: English Spanish Other _____ Student's preferred language: _____

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

Currently receiving outpatient mental health services: Yes No Undetermined If yes, Where? _____

In the past 7 days has the student been admitted to or released from: Psychiatric Hospitalization Juvenile Hall/Camp

If yes, Name of facility: _____ Release or Expected Discharge Date: _____

Please check all that apply

Trauma Exposure	Disruptive Behaviors
<input type="checkbox"/> Exposed to Community Violence <input type="checkbox"/> Serious Accidental Injury <input type="checkbox"/> Illness/ Medical Trauma <input type="checkbox"/> School Violence/ Bullying <input type="checkbox"/> Abuse*** <small>*All LAUSD staff are mandated to report suspected child abuse*</small> <input type="checkbox"/> Bereavement <input type="checkbox"/> Separation From Parent <input type="checkbox"/> Other _____	<input type="checkbox"/> Disorganized, makes careless mistakes <input type="checkbox"/> Gets out of seat and moves constantly <input type="checkbox"/> Interrupts and blurts out responses <input type="checkbox"/> Inattentive, distractible, forgetful <input type="checkbox"/> Destroys property <input type="checkbox"/> Angry towards others, blames others <input type="checkbox"/> Physical and/or verbal aggression towards others <input type="checkbox"/> Argumentative and defiant
Depressive Behaviors	Anxious Behaviors
<input type="checkbox"/> Sad, depressed or irritable mood <input type="checkbox"/> Low self-esteem, negative self-statements <input type="checkbox"/> Self-injurious/suicidal behaviors and/or thoughts Date RARD completed: _____ ISTAR# _____ Current Level of Risk: <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> Changes in sleep and/or appetite <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Diminished interest in activities <input type="checkbox"/> Low or decreased motivation	<input type="checkbox"/> Excessive worries or nervousness <input type="checkbox"/> School Refusal <input type="checkbox"/> Restless and on edge <input type="checkbox"/> Specific or excessive fears or phobias <input type="checkbox"/> Somatic complaints such as stomach aches, fast heart-beat, or headaches <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Clingy behavior <input type="checkbox"/> Appears distracted

For immediate concerns about danger to self or others, please contact LA County DMH ACCESS 800-854-7771 or LASPD Dispatch (213) 625-6631

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



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

Please check all that apply

Concerning Behaviors/Symptoms (within last 30 days)	School Concerns
Indication of substance use: <input type="checkbox"/> Yes <input type="checkbox"/> No Inappropriate sexual acts: <input type="checkbox"/> Yes <input type="checkbox"/> No Homicidal/Aggressive threats to others: <input type="checkbox"/> Yes <input type="checkbox"/> No Date RARD completed: _____ ISTAR# _____ Current Level of Risk <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High Suspected auditory or visual hallucinations: <input type="checkbox"/> Yes <input type="checkbox"/> No Previous psychiatric hospitalizations: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide dates : _____ _____	Significant decline in grades <input type="checkbox"/> Yes <input type="checkbox"/> No Truancy/poor attendance <input type="checkbox"/> Yes <input type="checkbox"/> No Does the student have an IEP <input type="checkbox"/> Yes <input type="checkbox"/> No Does the student have a 504 plan <input type="checkbox"/> Yes <input type="checkbox"/> No Interventions provided by school <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state: _____ _____ _____

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.

For immediate concerns about danger to self or others, please contact LA County DMH ACCESS 800-854-7771 or LASPD Dispatch (213) 625-6631

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



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

Parent/Guardian Acknowledgment Form

Date: _____

I acknowledge that school/community agency personnel at _____
School/community agency 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/agencia comunitaria _____ 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 comunice con la escuela de mi hijo para obtener informacion relacionada a esta recomendación.

Firma del Padre o Tutor _____ Domicilio _____

Numero de telefono _____ Telefono Celular _____

**For immediate concerns about danger to self or others, please contact LA County DMH ACCESS 800-854-7771 or
LASPD Dispatch (213) 625-6631**

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