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

SMH Referral Cover Sheet

Self-Referral (Ages 12 and up)

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.

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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
☐ Exposed to Community Violence	☐ Disorganized, makes careless mistakes
☐ Serious Accidental Injury	☐ Gets out of seat and moves constantly
☐ Illness/ Medical Trauma	☐ Interrupts and blurts out responses
☐ School Violence/ Bullying	☐ Inattentive, distractible, forgetful
☐ Abuse*** *All LAUSD staff are mandated to report suspected child abuse*	☐ Destroys property
☐ Bereavement	☐ Angry towards others, blames others
☐ Separation From Parent	☐ Physical and/or verbal aggression towards others
☐ **Other**_____	☐ Argumentative and defiant
Depressive Behaviors	**Anxious Behaviors**
☐ Sad, depressed or irritable mood	☐ Excessive worries or nervousness
☐ Low self-esteem, negative self-statements	☐ School Refusal
☐ Self-injurious/suicidal behaviors and/or thoughts	☐ Restless and on edge
Date RARD completed:_____ ISTAR#_____	☐ Specific or excessive fears or phobias
Current Level of Risk: ☐ ***Low*** ☐ ***Moderate*** ☐ ***High***	☐ Somatic complaints such as stomach aches, fast heart-beat, or headaches
☐ 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 or LASPD Dispatch (213) 625-6631

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

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Please check all that apply

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

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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California law dictates that parent/guardian consent be obtained for all minors seeking mental health services, with a few 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 18 years or older and do not want my parents contacted regarding this referral. Please contact me at _____to schedule an intake appointment.

☐ I am 18 years or older and would like to have my parent/guardian contacted 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 _____. ***Note:*** *a therapist will meet with you one time to determine if you can legally receive services without the consent of your parent/guardian. If we are unable to provide the service without their consent, the therapist will discuss your options with you.*

Printed Name:_____

Signature:_____

Thank you,

School Mental Health

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