



Student Medical Services Branch – Medical Services Division

School Enrollment Placement & Assessment Center - Referral Form

Send referrals to SEPA Panorama: ligia.bobadilla@lausd.net | SEPA LA: Alejandra.leyva@lausd.net

Date: _____ Name of Student: _____ D.O.B: _____

School: _____ Grade: _____

Address: _____ City: _____ Zip Code: _____

Parent/Guardian Name (if a Minor): _____ Parent Phone: _____

Student Phone: _____



Student Language: English Spanish Other _____

Home Language: English Spanish Other _____

Referral is for: Enrollment Vaccines Basic Needs Other _____

Name of person submitting referral: _____ Title: _____

School/Office: _____ Phone: _____

Has student been notified of referral? Yes No Has parent been notified of referral? Yes No

Case Notes (Please provide a little history on the case: _____

Office Use Only

Received By: _____

Parent Contact Date: _____ Student Contact Date: _____

Services Requested: Enrollment Vaccines Basic Needs Other _____

Services Provided/Follow-up Needed: _____