□ Crisis or □ Non-crisis

Montebello Unified School District
2012– 2013 Counseling Referral Form

Please FAX to **both** agency and Pupil & Community Services Division

Today's Date: _____ Referring School Personnel & School: _____
Student ID: _____ Grade: _____ Teacher: _____
Person completing form: _____ Title or relationship: _____
Student's Name: _____ DOB: _____ Age: _____
Address: _____ Ethnicity: _____ Primary Language: _____
_____ Health Insurance: □ Medi-cal # _____
_____ □ Healthy Families # _____
Phone #(s): _____ Cell Phone #: _____ □ Other _____
□ None _____
Mother's Name: _____ Father's Name: _____
Primary Language: _____ Primary Language: _____
Other Emergency Contacts: _____
Holder of Legal Custody: _____ Type: □Sole □ Joint □ Ward of the Court
Relationship to Child: _____ Legal Documentation of Custody? □ Yes □ No
Other Children living in the home: □ yes □ no

REASONS/CONCERNS (Please check all that apply.)

Please specify if these are issues for the identified client: □ yes □no whom: _____

Suicidal Ideas / Gestures ***Please clarify and specify known dates:*** _____

□ Suicide Attempt When: _____ How: _____
□ Anger / Irritability
□ Bullying: Intimidation / Aggressive behavior
□ Taking things that don't belong to him / her
□ Easily influenced by others
□ Inappropriate behaviors
□ No friend / Unable to make friends
□ Withdrawal / Crying / Non-compliance
□ Lack of self control / Impulsivity / Hyperactivity
□ Gang involvement
□ Sexually acting out
□ Loss of significant person by death, divorce, separation (who, when?): _____
□ Use of drugs / alcohol / other substances: _____
□ Loss of important peer relationships: _____
□ Conflict with peers / parents
□ Apparent alienation / rejection of or by parents / significant others / peers: _____
□ Family issues: _____
□ Difficulties at school: _____
□ Recent involvement with the law: _____

□ Anxiety
□ Lack of interest in school, in social activities
□ Truancy / Running away
□ Frequent mood changes
□ Referrals
□ Difficulty Concentrating
□ Self criticism
□ Profanity
□Change in personal appearance
□ Sad mood
□ Not following adult rules or requests / Oppositional
□ Other concerns:_____
□ Low self-esteem
□ Overeating / Loss of appetite
□ Giving away prized possessions
□ Grades slipping

Student / Family strengths: _____

Interventions provided with most current dates: _____

Remedial Steps Taken:
□ Referred to office
□ Reprimanded
□ Detention
□ In-house suspension
□ Saturday School
□ Suspension / Expulsion
□ Behavior log
□ Contacted Parent
□ Counseled
□ Court Disposition
□ Hospitalization _____
□ Medication (specify): _____
□ Other (specify):_____
□ SST (date): _____
□ SART (date): _____
□ SARB (date): _____
□ Special Ed Testing: _____

Other interventions / departments providing services:
□ DCFS □ DPSS □ Probation □ Regional Center □ Special Ed Dept.

Assigned to Agency:
□ ALMA □ Almansor □Bienvenidos □Enki □Maryvale □Pacific Clinics □Penny Lane □Roybal □SPIRITT □Whole Child

Name of Mental Health Professional: _____ Date: _____

Parent Name (Print):_____ Signature:_____ Date:_____

(Rev. Date: Oct. 2012)

Montebello Unified School District
Pupil & Community Services Division
123 S. Montebello Blvd., Montebello, CA 90640
(323) 887 - 7900

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF INFORMATION

Please FAX to **both** agency and Pupil & Community Services Division

Please Request Information From:	Please Send Information To:
Montebello Unified School District	Enki Health and Research Systems, Inc .
123 S. Montebello Blvd.	1000 Goodrich Blvd. .
Montebello, CA. 90640 FAX# (323) 887 – 5895	Commerce, CA. 90022 FAX # (626) 227 - 7019

I hereby authorize MUSD to release and/or disclose the information as indicated below to the provider, entity, or person I have indicated above.

_____ _____ _____
Name of Student ID # Date of Birth

_____ _____
Address City State Zip Code Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect until _____or for one year from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

REDISCLOSURE: I understand that the district may not lawfully further use or disclose the information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED

Check the box and initial which type of information is to be released and/or disclosed:

X Psychological Assessments
□ Speech/Language Reports
□ Audiological Reports
□ Occupational Therapy Reports
□ Physical Therapy Reports
□ Hospitalizations
□ General Medical Information (from _____ to _____)
X Mental Health (parent signature required)_____
X Other: school behavior reports and observations.

I request that the information released and/or disclosed pursuant to this authorization be used for the following purposes only: evaluate need for school-based therapy.

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. The copy is for me to keep.

_____ _____ _____
Date Signature of Parent/Student's Representative Indicate Relationship

Distrito Escolar Unificado de Montebello
Departamento de Servicios Estudiantiles y Comunidad
123 S. Montebello Blvd., Montebello, CA 90640
(323) 887 – 7900

SOLICITUD DE REPORTE Y/O REVELACIÓN DE INFORMACION

Please FAX to **both** agency and Pupil & Community Services Division

Solicite por favor la información de:	Por favor mande información a:
Montebello Unified School District	Enki Health and Research Systems, Inc. .
123 S. Montebello Blvd.	1000 Goodrich Blvd. .
Montebello, CA. 90640 FAX# (323) 887 – 5895	Commerce, CA. 90022 FAX # (626) 227 - 7019

Yo por la presente autorizo Montebello Unified School District para entregar y/o reveler información como fue indicado abajo al proveedor de asistencia, entidad, o persona que yo allá indicado arriba. Entregar y/o reveler los registros de información referente a:

_____ _____ _____
Nombre de estudiante ID # Fecha de nacimiento

_____ _____
Dirección Ciudad Estado Zona Postal Número de Teléfono

DURACIÓN: Esta autorización debe estar en efecto inmediatamente, y deberá permanecer vigente hasta _____ (fecha) o por un año empezando con la fecha de firma si la fecha no fue indicada.

REVOCACIÓN: Esta autorización se puede revocar por escrito por el abajo firmante en cualquier momento antes de entregar información del partido que revela. La revocación escrita no afectará ninguna acción tomada referente a esta autorización antes de que la revocación escrita sea recibida.

REVELACIÓN: Entiendo que el Distrito puede no lícitamente el uso adicional o reveler la información a menos que otra autorización se obtenga de mi o a menos que la revelación se requiera específicamente o sea permitida por la ley.

ESPECIFIQUE LOS REGISTROS QUE DEBEMOS ENTREGAR Y/O REVELAR

Verifique la caja y su inicial de cuál tipo de información deberá ser dada o revelada:

X Evaluaciones Psicológicas
□ Reportes de Habla y Lenguaje
□ Informes Audiológicos
□ Informes de Terapia Ocupacional
□ Informes de Terapia Físico
□ Información Médica General (de _____ a _____)
□ Hospitalizaciones
X Salud Mental
X Otro: documentos y observaciones de comportamiento en la escuela.

Solicito que la información entregada y/o revelada referente a esta autorización sea utilizada solo para el propósito siguiente: desarrollar plan tratamiento.
Una copia de esta autorización es válida como una original.
Yo tengo el derecho de recibir una copia de esta autorización. La copia es para que yo la tenga.

_____ _____ _____
Fecha Firma de Padre/Representante del Estudiante Relación