

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 # _____

Other _____

None _____

Phone #(s): _____ Cell Phone #: _____

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 No friend / Unable to make friends

Bullying: Intimidation / Aggressive behavior Withdrawal / Crying / Non-compliance

Taking things that don't belong to him / her Lack of self control / Impulsivity / Hyperactivity

Easily influenced by others Gang involvement

Inappropriate behaviors 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 Self criticism Low self-esteem

Lack of interest in school, in social activities Profanity Overeating / Loss of appetite

Truancy / Running away Change in personal appearance Giving away prized possessions

Frequent mood changes Sad mood Grades slipping

Referrals Not following adult rules or requests / Oppositional

Difficulty Concentrating Other concerns: _____

Student / Family strengths: _____

Interventions provided with most current dates: _____

Remedial Steps Taken: Behavior log SST (date): _____

Referred to office Contacted Parent SART (date): _____

Reprimanded Counseled SARB (date): _____

Detention Court Disposition Special Ed Testing: _____

In-house suspension Hospitalization _____

Saturday School Medication (specify): _____

Suspension / Expulsion Other (specify): _____

Other interventions / departments providing services:

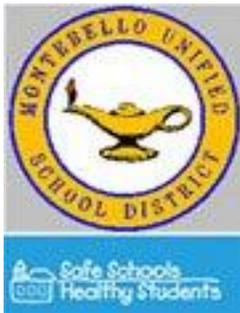
DCFS DPSS Probation Regional Center Special Ed Dept.

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: _____



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:

Montebello Unified School District
123 S. Montebello Blvd.
Montebello, CA. 90640 FAX# (323) 887 – 5895

Please Send Information To:

Pacific Clinics
9829 Carmenita Road Suite H
Whittier, CA. 90605 FAX # (626) 844 - 0481

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

	ID #	Date of Birth		
Name of Student				
	City	State	Zip Code	Telephone Number
Address				

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.

REVOCAION: 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.

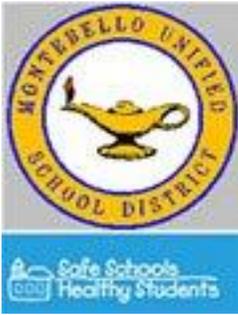
REDISCLASURE: I understand that the district may not lawfully further use or disclose the information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED Check the box and initial which type of information is to be released and/or disclosed:

- Psychological Assessments
- Speech/Language Reports
- Audiological Reports
- Occupational Therapy Reports
- Physical Therapy Reports
- Hospitalizations
- General Medical Information (from _____ to _____)
- Mental Health (parent signature required) _____
- 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

Pacific Clinics

123 S. Montebello Blvd.

9829 Carmenita Road Suite H

Montebello, CA. 90640 FAX# (323) 887 – 5895

Whittier, CA. 90605 FAX # (626) 844 - 0481

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

Nombre de estudiante	ID #	Fecha de nacimiento
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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 revelar 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	<u>Verifique la caja y su inicial de cuál tipo de información deberá ser dada o revelada:</u>			
	<input checked="" type="checkbox"/> Evaluaciones Psicológicas <input type="checkbox"/> Reportes de Habla y Lenguaje <input type="checkbox"/> Informes Audiológicos <input type="checkbox"/> Informes de Terapia Ocupacional <input type="checkbox"/> Informes de Terapia Físico <input type="checkbox"/> Información Médica General (de _____ a _____) <input type="checkbox"/> Hospitalizaciones <input checked="" type="checkbox"/> Salud Mental <input checked="" type="checkbox"/> Otro: <u>documentos y observaciones de comportamiento en la escuela.</u>			

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
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