**Student Support and Health Services Department**



*SCUSD’s gateway for connecting students and families with support services*

**REFERRAL FOR SUPPORT SERVICES**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| **Student Name** |  | **School** |  | **Grade** |

***Have you discussed your concerns with the student?***  **Y**  **N** ***Is student aware of this referral?***  **Y  N**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| **Parent/Guardian 1** |  | **Phone** |  | **Language** |

***Have you discussed your concerns with this parent****?*   **Y  N** ***Is parent aware of this referral?***  **Y  N**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| **Parent/Guardian 2** |  | **Phone** |  | **Language** |

***Have you discussed your concerns with this parent****?*   **Y  N** ***Is parent aware of this referral?***  **Y  N**

**Areas of Concern:**

|  |  |  |
| --- | --- | --- |
| 1 Academic | 6 Family Stress | 11 Mental Health/Wellness |
| 2 Attendance | 7 Financial | 12 Recreation/After School |
| 3 Legal | 8 Transportation | 13 Health Issues (Physical/Dental/Vision) |
| 4 Behavior | 9 Food/Clothing/Shelter (Basic Needs) | 14 Lack of Health Insurance Coverage |
| 5 Peer Relationships | 10 Ethnic/Cultural Identity | 15 Sexual Orientation/Gender Identity |

**Please provide a more detailed description of these issues and any other concerns (use back if needed):**

**Are you aware of any other staff and/or service providers that are involved with this student/family? If so, please list below:**

**\*Is this student:** **receiving Special Education services? Y Ncurrently homeless? Y** **N in foster care?** **Y** **N**

**\*Does the student and/or family have health insurance?**  **Y**  **N**  *(If no, be sure to check Lack of Health Insurance Coverage as an Area of Concern above.)*

**What type of health insurance?**  **Medi-Cal**  **Healthy Families**  **Kaiser**  **HMO/PPO (Private Insurance)**  **Other**

**If necessary, please describe coverage below:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | Principal  VP  Office Manager  Office Assistant  Teacher Nurse  School Psych.  School Counselor  Parent/Caregiver ­­­­­­­­  Other: | | |
| ***Name of Person Making Referral*** |  | ***Title*** | | |
|  | | |  |  |
| ***School/Department/Organization*** | | |  | ***Phone*** |
|  | | |  |  |
| ***E-mail*** | | |  | ***Date*** |

**Please fax completed form to 433-5372. For more information, contact the Connect Center at 643-2354.**