**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.**