SCUSD's gateway for connecting students and families with support services

REFERRAL FOR SUPPORT SERVICES

Student Name

Have you discussed your concerns with the student?  □ Y  □ N

School
Is student aware of this referral?  □ Y  □ N

Grade

Parent/Guardian 1

Have you discussed your concerns with this parent?  □ Y  □ N

Phone
Is parent aware of this referral?  □ Y  □ N

Language

Parent/Guardian 2

Have you discussed your concerns with this parent?  □ Y  □ N

Phone
Is parent aware of this referral?  □ Y  □ N

Language

Areas of Concern:


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  □ N  Homeless?  □ Y  □ N  In foster care?  □ Y  □ N  In GATE?  □ Y  □ N

*Does the student and/or family have health insurance?  □ Y  □ N  (If no, please check Lack of Health Insurance Coverage above.)

What type of health insurance?  ☐ Medi-Cal  ☐ Kaiser – Private  ☐ HMO/PPO (Private Insurance)  ☐ Other

If necessary, please describe coverage below:


Principal/VP  MOC  Soc. Worker/Coord.  Office Mgr/Asst.
Teacher  Nurse  School Psychologist  School Counselor
Parent/Caregiver  Student H&P Office  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.

Revised 9/3/2013