**Student Support and Health Services Department**

**Connect Center**

*SCUSD’s gateway for connecting students and families with 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 MUST be made aware of referral except in the case of possible safety concerns (e.g. child abuse) or LGBTQ-sensitive concerns).**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|       |  |       |  |       |
| **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 (e.g. Bus passes) | [ ] 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 DO NOT fax suicide risk assessment requests – CALL!**

**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:**

**\*Special Education? [ ]  Y [ ]  NHomeless? [ ] Y** **[ ]  N Foster Youth?** **[ ]  Y** **[ ]  N GATE? [ ]  Y [ ]  N CSEC? [ ]  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 [ ]  HMO/PPO (Private Insurance)**  **[ ]  Other (e.g. Tri-Care for military families)**

**\***D**escribe coverage below: [ ]  Kaiser**  **[ ]  Molina [ ]  Health Net [ ]  Anthem Blue Cross [ ]  Other (e.g. Aetna, Sutter, etc.)**

**Referral Source:**

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

**Please fax completed form to 433-5372 or email to** **daniel-cisneros@scusd.edu****.**

**For more information, contact the Connect Center at 643-2354.**