**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**](mailto:daniel-cisneros@scusd.edu)**.**

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