Jurupa Unified School District
BEHAVIORAL HEALTH SERVICES
REFERRAL FORM

REFERRALS TO BE MADE TO PARENT INVOLVEMENT & COMMUNITY OUTREACH (JUSD)
EMAIL: Behavioral_Health@JUSD.k12.CA.US
ALL REFERRALS TO BE LABELED CONFIDENTIAL & EXPECT CONFIRMATION

Date:	Referred by:	Phone:	
If you are referring a student, is the parent/guardian aware the referral is being made? □ Yes □ No			
If referred by other than parent or guardian please indicate date/ time guardian was made aware of the referral.			
Referring School Site:	Student ID #:		
Student Name:	DOB:	Age & Grade:	Gender: □ Female □ Male
Address:	City/Zip:		Home Phone: ( )
Parent/Legal Guardian:	Best Contact Phone: ( )	Parents Primary Language:	

List Children living in the home:	School:	Age:	DOB:
1. _____	1. _____	1._____	1._____
2. _____	2. _____	2._____	2._____
3. _____	3. _____	3._____	3._____
4. _____	4. _____	4._____	4._____
5. _____	5. _____	5._____	5._____
6. _____	6. _____	6._____	6._____

Does the student have an active IEP? □ Yes □ No
If yes, are they currently receiving services through ERMHS (Educationally Related Mental Health Service)? □Yes □No

Stressors: □ Homeless □ Dealing with parental divorce □ Parent incarcerated □ Domestic Violence

REASONS/CONCERNS (Please check all that apply)

Conduct Issues
□ Gang involvement □ Involvement with the law
□ Profanity □ Suspensions/expulsions
□ Truancy / running away
□ Taking things that don't belong to him/her

High Risk Behaviors
□ Suicidal thoughts/thinking, talking about death*
□ Suicidal Ideas/Gestures/Self-Harm/Cutting*
□ Suicide Attempt *Please clarify and specify known date:*
When: _____
How: _____

Anger
□ Irritability □ Lack of self-control
□ Aggressive towards peers* □ Physical Aggression*
□ Aggressive towards adults* □ Verbal Aggression

Social
□ Has few friends
□ Bullying-physical/verbal*
□ Accepted by peers
□ Rejected by peers
□ Limited social skills
□ Associates with a negative peer group
□ Does not get along well with others
□Other:_____

□ **Substance Abuse***
Describe:_____
_____

Difficulties at School
□ Academic
□ Grades slipping
□ Lack of concentration
□ Behaviors out of context/inappropriate
□ No friends / unable to make friends

Grief/Loss
□ Alienation/rejection by parents, significant others
□ Loss of significant peer relationships
□ Loss of significant person by death, divorce, or separation

LEARNING WITHOUT LIMITS

***** *EC 46010.1 School authorities may excuse any pupil in grades 7-12 from the school for the purpose of obtaining confidential medical services without the consent of the pupil's parent or guardian.*

Medical/Health Issues □ Decline in general health □ Poor hygiene □ Preexisting medical diagnosis:	□ Medication(s): _____ □ Other: _____	**Physical Disabilities** □ Visual □ Physical impairment –mobility □ Hearing	□ Developmental □ Speech □ Other physical impairment □ Unknown: _____
Mood Disturbances □ Anxious/Tense □ Worried/Fearful □ Self-criticism □ Sad mood	□ Low self-esteem □ Withdrawal □ Fatigue/Tired □Defiant/Noncompliance	□ Lack of interest in school/social activities □ Change in personal appearance □ Difficulty concentrating	□ Frequent mood changes □ Giving away prized possessions □ Overeating/loss of appetite
Early Childhood (0-5 years old) □ Hurts Self* □ Hurts others* □ Hurts adults* □ Tantrums □ Easily upset □ Restless □ Unable to calm down □ Climbs on furniture*	□ Vomiting/Nausea □ Urinating □ Aggressive play □ Throws things* □ Clings to adult □ Avoids adults	□ Avoids other children; does not interact □Grabs other children or toys* □ Crashes into other children* □ Bothers or interferes with others □ Is avoided by other children	□ Sleep issues (reported by parents) □ Unable to sit for activities □ Persist at one activity □ Difficulty with transitions

REQUIRED: Additional information for reason for referral: _____

_____

Any previous interventions: _____

_____

MEDICAL INSURANCE COVERAGE		
Medi-Cal? □ Yes □ No	Medi-Cal ID # (NOT IEHP/Molina #)	Medi-Cal Issue Date:
Medi-Cal from Riverside County? □ Yes □ No	Does the family have transportation to nearby clinics? □Yes □No	
□ HMO (Medi-Cal) □ HMO Employer □ Private Insurance □ No Medical Insurance		
OFFICE USE ONLY		
Date referral was received:	Date referral was sent:	

***The students parent/guardians have been verbally informed and referral for student has been agreed upon by the parent/guardians.**

_____ _____

Signature of Staff making the referral | Staff- Print Name | Date

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