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:	

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JURUPA UNIFIED SCHOOL DISTRICT

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize use or disclosure of the named individual's health information.

DATE:		
STUDENT/CLIENT		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY, STATE:	ZIP CODE:
TELEPHONE NUMBER:		DATE OF BIRTH:

THE FOLLOWING ORGANIZATION IS AUTHORIZED TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF REFERRAL/TRIAGE

NAME OF ORGANIZATIONS:

JURUPA UNIFIED SCHOOL DISTRICT
4850 Pedley Rd., Jurupa Valley, CA 92509
(951) 360-4100

MFI RECOVERY CENTER
5870 Arlington Ave., Suite 103, Riverside, CA 92504
(951) 683-6596

FAMILY SERVICES ASSOCIATION
21250 Box Springs Rd., Suite 212, Moreno Valley, CA 92557
(951) 686-1096
8172 Magnolia Ave, Riverside, CA 92504 (951) 353-0129

RIVERSIDE UNIVERSITY HEALTH SYSTEM - BEHAVIORAL HEALTH
3125 Myers St., Riverside, CA 92503 (951) 358-4840
3075 Myers St., Riverside, CA 92503 (951) 358-4625
1195 Magnolia Ave., Corona, CA 92879 (951) 273-0608
2085 Rustin Ave., Riverside, CA 92507

BORREGO HEALTH
8856 Arlington Ave., Riverside, CA 92503 (951) 710-3970 1970
University Ave., Riverside, CA 92507 (951) 213-3450
5565 Troth St., Jurupa Valley, CA 91752 (951) 710-3987

TESSIE CLEVELAND COMMUNITY SERVICES CORP.
3576 Arlington Ave., Suite 100, Riverside, CA 92506
(951) 374-1555 ext. 8010

ALMA FAMILY SERVICES
3924 Riverview Dr., Jurupa Valley, CA 92509
(951) 416-1111

HOUSE OF RUTH
3924 Riverview Dr., Jurupa Valley, CA 92509

AMERICA'S BEST CONTACT & EYEGLASSES
1285 Cantu Galleano Ranch Rd., Eastvale, CA 91752

THIS INFORMATION MAY BE OBTAINED OR RELEASED BY THE FOLLOWING ORGANIZATION	
NAME OF ORGANIZATION: **JURUPA UNIFIED SCHOOL DISTRICT, BEHAVIORAL HEALTH** **3924 RIVERVIEW DRIVE** **JURUPA VALLEY, CA 92509 951-416-1572**	
CASE DATE:	PURPOSE OF REQUEST: REFERRAL/TRIAGE
THE FOLLOWING INFORMATION IS TO BE DISCLOSED:	
All records including, but not limited to: Behavioral Health Referral	Other: ______N/A________________
RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to the information that has already been released based on this authorization.	
SENSITIVE INFORMATION: I understand that the information in my record may include information about behavioral or mental health services or treatment for alcohol and drug abuse.	
PHOTOCOPY, FAX or EMAIL: I agree that a photocopy, fax or email of this authorization is to be considered as effective as the original.	
EXPIRATION: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ____ If I do not specify an expiration date, event, or condition, this authorization will expire in one (1) calendar year from the date it was signed.	
REDISCLOSURE: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be re-disclosed and no longer protected. California law generally prohibits recipients of my health information from re-disclosing such information except with my written authorization or as specifically required or permitted by law.	
RIGHTS OF ACCESS: I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section 164.524 I have a right to receive a copy of this authorization. I would like a copy of this authorization. YES NO	
SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE	
Signature of Student/Client:	Date:
Signature of Parent/Guardian (if minor):	Date:
If signed by Legal Representative, relationship of individual:	
Signature of School Staff:	Date: