MISSION MIDDLE SCHOOL
BEHAVIORAL HEALTH SERVICES
REFERRAL FORM

PARENT INVOLVEMENT & COMMUNITY OUTREACH
3924 Riverview Drive, Jurupa Valley, CA 92509 (951)360-4175
TESSIE CLEVELAND COMMUNITY SERVICES CORP.
3576 Arlington Avenue Suite 100, Riverside CA 92506 (951) 374-1555 – (951) 394-7426 fax – email rivesidereferals@tccsc.org

Date:	Referred by:	Phone:

If referred by other than parent or guardian please indicate date/ time guardian was made aware of the referral.

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.

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

REASONS/CONCERNS (Please check all that apply)

If you are referring a student, is the parent/guardian aware the referral is being made? ☐ Yes ☐ No

Anger
□ Irritability
□ Lack of self-control

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

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

Mood Disturbances
□ Anxiety
□ Change in personal appearance
□ Depression
□ Difficulty concentrating
□ Frequent mood changes
□ Giving away prized possessions
Self-criticism
□ Sad mood
□ Low self-esteem
□ Overeating / loss of appetite
□ Withdrawal/crying/non-compliance
□ Lack of interest in school/social activities

□ Substance Abuse:
_____
_____
_____
_____

LEARNING WITHOUT LIMITS

Difficulties at School □ Academic □ Grades slipping □ 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, separation
Social □ Associates with a negative peer group □ Has few friends □ Bullying-physical / verbal □ Accepted by peers □ Rejected by peers □ Limited Social skills □ "Class clown" □ Does not get along well with others □ Other:_____	**Medical/Health Issues** □ Decline in general health □ Poor hygiene □ Preexisting medical diagnosis:_____ □ Medication(s):_____ □ Other:_____

Physical Disabilities

□ Visual □ Hearing □ Speech □ Physical impairment –mobility □ Developmental □ Other physical impairment □ unknown

CLIENT DISPOSITIONING

DOES THE CLIENT HAVE AN OPEN DCFS CASE? □ YES □ NO	
DOES THE CLIENT CURRENTLY ENGAGE IN SUBSTANCE ABUSE? □ YES □ NO	
HAS THE CLIENT EXPERIENCED ANY EXPOSURES TO TRUAMA THAT HAS RESULTED IN ONGOING DISTRESS? (provide description) □ YES □ NO	
HAS THE CLIENT ENGAGED IN ANY HIGH RISK BEHAVIOR OR EXPERIENCED EXTREME TRAUMA IN THE LAST 72 HOURS (i.e. suicide attempt, psychiatric hospitalization, psychotic break / mental breakdown, drug overdose, death of immediate family member) □ YES □ NO	

REQUIRED-Additional information for reason for referral:_____

Any previous interventions: _____

MEDICAL INSURANCE COVERAGE

☐ Medi-Cal	Medi-Cal#	Medi-Cal Issue Date:	
☐ HMO (Medi-Cal)	☐ HMO Employer	☐ Private Insurance	☐ No Medical Insurance

OFFICE USE ONLY

Date referral was received:	**Date referral was sent:**