Didi Hirsch MENTAL HEALTH SERVICES

DIDI HIRSCH MENTAL HEALTH SERVICES SCHOOL-BASED REFERRAL

Name of School:		Date of Referral:	
STUDENT LAST NAME:		STUDENT FIRST NAME:	
Date of Birth:	Age:	Preferred Name:	Grade:
Student Language:		Living Situation:	
Gender:		Ethnicity:	
☐ Has Medi-Cal:	*Student's Medi-Cal #:*	SSN:	☐ Uninsured
Name of Parent/Guardian:		Relationship (to child):	
Address:		Email:	
Language of Parent:		Home / Cell / Work Phones:	

REFERRAL INFORMATION

Staff Making Referral:		Position:	
Staff Phone:	School Phone:	Email:	

☐ *I have discussed referral with parent/guardian who is interested* ☐ *Referral was requested by parent/guardian*

☐ Family is open to and has access to telehealth technology: ☐ Video ☐ Phone ☐ Both ☐ Not interested in telehealth

Reasons for Referral:

CONCERNS (*check all that apply: * indicates risk*)

☐ Attention / concentration difficulties	Trauma history: ☐ Physical abuse ☐ Sexual abuse	☐ Aggressive ideation / threats*
☐ Hyperactive / impulsive behaviors	☐ Neglect ☐ Community Violence	☐ Aggressive behaviors (history or current)*
☐ Problems in peer relationships	☐ Sad / feeling helpless / hopeless / worthless	☐ Drug possession / use / abuse
☐ Problems in relationships with adults	☐ Recent loss(s) / grief ☐ History of loss(s)	☐ Risky behaviors
☐ Excessive worry/anxiety	☐ Mood swings / irritability / easily angered	☐ Probation
☐ Withdrawn / shy / isolating	☐ Sleeping too much / sleeping too little	☐ Odd thinking / hallucinations / delusions
☐ Family issues	☐ Current suicidal ideation* Assessed: ☐ Yes ☐ No	☐ Social skills difficulties
☐ Open DCFS case	☐ Self-harming behaviors (cutting, burning, etc.)	☐ Immigration concerns

ACTIONS TAKEN BY THE SCHOOL PRIOR TO INITIATING REFERRAL *(check all that apply)*

☐ Classroom modifications	☐ SST / SSPT / COST ☐ 504 Plan	☐ Prior outside mental health referral(s)
☐ Parent conference(s)	☐ IEP: ☐ OHI ☐ SLD ☐ ED ☐ LAS ☐ AUT	☐ PMRT / MHET referral(s)
☐ Suspension	☐ DIS Counseling ☐ ERMHS / ERICS Counseling	☐ Prior Hospitalization(s)

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Completion of this form authorizes the disclosure of your contact information, school information and Protected Health Information (PHI) noted above; consistent with federal[1] and state laws[2] concerning privacy, such information cannot be disclosed without your written authorization. All items must be completed in order for the authorization to be valid.

I grant permission for disclosure of the above information to assist Didi Hirsch MHS (Provider) to determine the need for voluntary mental health services for my child that may be offered at the school and to arrange for billing of Medi-Cal for assessment and any provided services. I understand that I may be contacted by a representative of the Provider for any additional information needed in order to process the referral, schedule an initial assessment or offer additional resources.

I understand that the Provider is not part of the regular and ongoing program of any school, school district or charter organization. *I understand that the school, school district or charter organization does not assume responsibility for the services provided by the Provider nor for any fees that may be charged.*

School Name:		Principal:	
Parent / Guardian Print Name:		☐ I provided verbal consent for this referral.	
Student Print Name:		☐ I provided verbal consent for this referral.	
Parent / Guardian Signature:		Date:	
Student Signature (18 years or older):		Date:	

[1]Family Education Rights and Privacy Act of 1974 (FERPA) Federal Regulation (20 U.S.C. § 1232g; 34 CFR §99) [2]California Welfare and Institutions Code Section 5328

Email Completed Referral Form to School-Based Coordinator:

Didi Hirsch Metro Child and Family Program (213) 381-3626 Fax: (213) 380-8923