Service Area: 1☐ 2☐ 3☐ 4☐ 6☐ 7☐

Services preferred at: Home☐ Office☐ School☐

Minute Order/Custody Docs: Yes☐ No☐

Copy Medi-cal/Insurance card: Yes☐ No☐

HEAL. HOPE. THRIVE.
Hathaway-Sycamores
CHILD AND FAMILY SERVICES

Referral Support Center

Referral Center Contact : 1(844) 222-2377
Agency Contact: (626) 395-7100
Fax: (323) 837-9719
Email: Referral@hscfs.org

Referring Party:

Referral Date: _____

Name: _____ Phone:_____ Agency/Role: _____

Are the client and family aware of this referral? ☐Yes ☐No

Client Information:

Name: _____ (M.I.):____ Last Name:_____ Sex: ☐F ☐M ☐Other DMH ID #: _____

D.O.B:_____ Age: _____ Race/Ethnicity: _____ Primary Language: _____

Soc. Sec. #:_____ Medi-cal: ☐Yes ☐ No If yes, Medi-cal #: _____

School: _____Grade:_____

Bio Mother's Name: _____ Bio Father's Name: _____

Primary Caregiver:

Client currently lives with: ☐Mother ☐Father ☐Guardian ☐Foster Parent ☐Self ☐Other: _____

Caregiver's Name:_____ Primary language:_____ English Speaker: ☐Yes ☐No

Phone: _____ Alternative Phone: _____ Leave message: ☐ Yes ☐No

Address: _____ City: _____ Zip:_____

When can we call? Mon☐ Tue☐ Wed☐ Thurs☐ Fri☐ Sat☐ Sun☐ Time:_____

Clinical Information:

Currently receiving outpatient mental health services? ☐ Yes ☐No ☐ Unknown *If yes, from where/whom?*_____

Been on psychotropic medication w/in the past 30 days? ☐ Yes ☐No ☐ Unknown Refill date: _____

Release from (in the past 7 days): ☐Inpatient ☐Juvenile Hall ☐Jail ☐N/A *Expected release/discharge date?*_____

If released from inpatient facility, name of facility: _____

Experiencing the following:

☐ Suicidal: Ideation/Intent/Hx ☐ w/in *3 mo. ☐ Homicidal: Ideation/Intent/Hx ☐ w/in *3 mo. ☐ Self-Harm ☐ w/in *3 mo. ***High Risk**	☐Trauma/Abuse/DV/Bullying ☐Hallucinations (Visual/Auditory) ☐Flashbacks ☐Fearfulness ☐Panic attacks ☐Nightmares ☐Anxious	☐Aggression/Destruction of property ☐Disruptive behaviors ☐Defiance/ Non-compliant ☐Difficulties in school ☐Peer problems ☐Difficulty concentrating ☐Impulsive/Hyperactive/Inattentive ☐Temper Tantrums/ Mood changes	☐Depressed/Sadness/Cries Often ☐Isolation/Withdrawn ☐Irritability ☐Bedwetting/Soiling ☐Substance use

Additional Comments/concerns?

_____

_____

_____

INFORMED CONSENT FOR PROVIDER CONTACT

Date: _____

I hereby authorize _____ school to disclose contact information regarding
School Name

_____, date of birth _____. The information is
Student Name

being given to assist my child to obtain medical/mental health services by _____
Provider's Name

_____. I understand that the Provider is not
Address **City** **Zip Code**

a part of the regular and ongoing program of the school or the Los Angeles Unified School District. This service is made available at the school/site for my convenience to obtain health/mental health services for my child. *I understand that the Los Angeles Unified School District does not assume responsibility for the services provided by the Provider nor the fees that may be charged.*

_____ _____

Signature of Parent/Legal Guardian **Date**

CONSENTIMIENTO INFORMADO PARA PROVEEDOR DE SERVICIOS

Fecha: _____

Por este medio autorizo que_____revele información de contacto concerniente
Nombre de la Escuela

a_____, fecha de nacimiento_____. Esta
Nombre del Alumno

información se provee con el fin de ayudar a mi hijo/a en obtener servicios médicos o de salud mental ofrecidos

por_____.
Nombre del Proveedor de Servicios **Domicilio** **Ciudad** **Código Postal**

Entiendo que el proveedor de servicios no forma parte del programa regular y actual del Distrito Escolar Unificado de Los Ángeles. Este servicio se pone a la disposición en el plantel escolar para mi conveniencia en obtener servicios de salud y servicios de salud mental para mi hijo/a. Entiendo que el Distrito Escolar Unificado de Los Ángeles no se hace responsable por los servicios prestados por el Proveedor ni por los posibles honorarios por cobrarse.

_____ _____

Firma del Padre o Tutor Legal **Fecha**

[1]

[1] 14889 (ALM) Translated By The LAUSD Translations Unit, Spanish