



Desert/Mountain SELPA Children's Center

17800 Highway 18, Apple Valley, CA 92307

(760) 242-6336 • (760) 946-0819 FAX

Referral for Behavioral Health Services

Students 1st through 12th Grade

Referred by: _____ Phone Number: _____ Date: _____

Client/Student Name: _____ Social Security Number: _____

Date of Birth: _____ Age: _____ Grade: _____ Gender: Male Female

Attending School: _____ Teacher: _____

Parent/Guardian: _____ Home Phone: _____ Work Phone: _____

Street Address: _____ City: _____ Zip Code: _____

Mailing Address: _____ City: _____ Zip Code: _____

Insurance Information: Pacific Care _____ IEHP _____ Tri Care _____ Molina _____ Cash Pay _____

Medi-Cal Eligible? No Yes Medi-Cal Benefits Number: _____ Issue Date: _____

CONSENT TO EXCHANGE CONFIDENTIAL/PRIVILEGED INFORMATION

I authorize _____ and the Desert/Mountain SELPA Children's Center to exchange confidential/privileged information, including information regarding mental health treatment, in order to develop and implement a service plan for _____

(Client/Student Name)

This authorization is limited to the following specific types of information:

- All records without exception
- Scheduling and treatment attendance information
- Diagnosis/assessment information
- Treatment plan
- Treatment summary
- Social history
- Other: _____

This authorization is further limited in the following manner: _____

RESTRICTION: I understand that the parties to this release may not further use or disclose the exchanged information unless another authorization is obtained or unless such use or disclosure is specifically required or permitted by law.

DURATION: This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance herein and, if not earlier, it shall terminate without express revocation on: _____

(Date, Event, or Condition)

I understand that I have the right to refuse to sign, or to limit the scope of, this consent form. I have read this consent carefully and have had all my questions answered. I understand that I am entitled to receive a copy of this consent form.

Date: _____ Parent/Guardian Signature: _____

Date: _____ Agency Signature (CFS, etc.): _____

Date: _____ Administrator Signature: _____ Title: _____

CONFIDENTIAL CLIENT INFORMATION

See Welfare & Institutions Code section 5328, 10850, and 18968.46; Civil Code sections 56; 42 CFR 2.31, 2.33, and 2.35; Education Code section 49075; Evidence Code section 900 - 1070 and Health & Safety Code section 123100.



Desert/Mountain SELPA Children's Center

17800 Highway 18, Apple Valley, CA 92307

(760) 242-6336 • (760) 946-0819 FAX

Medi-Cal Behavioral Health Services Referral Checklist

Students 1st through 12th Grade

Date: _____

Client/Student Name: _____ Form Completed By: _____

Teacher Name: _____ School: _____ Grade: _____

Students often exhibit behaviors or changes of behavior that cause concern among school personnel. This checklist may be used as a guide to help determine if a behavioral health referral is appropriate for a student and their family. If indicators from this checklist persist following standard teacher-initiated and school-based interventions, consider a referral for behavioral health services.

Academic Indicators

- | | | |
|---|--|--|
| <input type="checkbox"/> Giving Up Easily | <input type="checkbox"/> Poor Effort | <input type="checkbox"/> Motor Coordination Below Peers |
| <input type="checkbox"/> Incomplete Work | <input type="checkbox"/> Poor Motivation | <input type="checkbox"/> Deterioration in Academic Performance |

Behavioral Indicators

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Abusive Language | <input type="checkbox"/> Class Clown | <input type="checkbox"/> Hyperactive |
| <input type="checkbox"/> Absences or Tardiness | <input type="checkbox"/> Constantly Leaving Classroom | <input type="checkbox"/> On Probation |
| <input type="checkbox"/> Argumentative/Defiant | <input type="checkbox"/> Destruction of Property | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Attention Seeking | <input type="checkbox"/> Dishonesty | <input type="checkbox"/> Disruptive |
| <input type="checkbox"/> Cheating | <input type="checkbox"/> Threatening (provide detail): _____ | |
| <input type="checkbox"/> Inappropriate Display of Affection with Peers/Teachers: _____ | | |

Emotional Indicators

- | | | |
|---|--|--|
| <input type="checkbox"/> Bladder or Bowel Accidents | <input type="checkbox"/> Irritable | <input type="checkbox"/> Overly Responsible |
| <input type="checkbox"/> Defensive | <input type="checkbox"/> Isolated from peers/target of teasing | <input type="checkbox"/> Paranoid (feels picked on, watched, etc.) |
| <input type="checkbox"/> Falls Asleep | <input type="checkbox"/> Lethargic | <input type="checkbox"/> Uncontrollable or Excessive Giggling |
| <input type="checkbox"/> Hysterics (excessive crying) | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Withdrawn |

Family/Environmental Indicators

- | | |
|--|---|
| <input type="checkbox"/> CPS Involvement | <input type="checkbox"/> Other Difficulties in Family (financial, health, separation) |
| <input type="checkbox"/> Mental Abuse | <input type="checkbox"/> Other Problematic Behaviors Reported by Parents |
| <input type="checkbox"/> History or Recent Removal from Home | <input type="checkbox"/> Substance Abuse by Parents and/or Significant Others |
| <input type="checkbox"/> Other Siblings Exhibit Problems | <input type="checkbox"/> Suffered Recent Loss (move, divorce, death, etc.) |
| <input type="checkbox"/> Speaks Angrily of Parents | |

Please describe the behaviors and attitudes that are causing concern: _____

What would you like to see changed? What goals would you like to see achieved? _____

Are you aware of any history of past abuse, family violence, divorce, or other trauma? _____

Action taken previously: _____

Other information we may need to know: _____