COJUSD Student Support Services Referral Form

CONFIDENTIAL

12623 Ave. 416
Orosi, CA. 93647
(559) 528-4763
www.cojusd.org

Date:	**Referral By/Title/Email:**
Student Name/DOB:	**School/Grade/Teacher:**
Parent/Guardian:	**Address/Phone:**

Reason for Referral (Please use examples and be specific. What did they say or do?)

What has been tried (i.e. met with student, contacted parent, detention, provided tutoring, referred to admin, had meeting)?

What do you hope to be achieved through this referral?

Select ALL that apply

Health/Safety	Psychological/Personal/Social	Family/Domestic Issues
☐ Harm to self (i.e. suicide, cutting)	☐ Risk of fighting/ Conflict with peers	☐ Domestic violence
☐ Threat: written or verbal	☐ SCAR Report	☐ Substance abuse
☐ Pregnancy/sexual activity	☐ Risk of running away	☐ Suspected gang affiliation
☐ Suspected substance abuse	☐ Crying, grieving, emotional	☐ Financial difficulties (i.e. no work)
☐ Sudden weight loss/gain	☐ Bullying – (victim or aggressor?)	☐ Housing needs (i.e. food, bills, migrant, homeless, recent arrival, clothing)
☐ Needs physical/dental exam	☐ Mental health condition	☐ Parenting Skills
☐ Reoccurring lice	☐ Poor impulse control	☐ Support network/Family
☐ Medical condition	☐ Support network/Friends	☐ Divorce/Single Parent
☐ Frequent physical complaints/low energy	☐ Change in behavior (i.e. motivation, aggressive, depressed, defiant, etc.)	☐ Other:
☐ Sleeping in class, excessively tired	☐ Withdrawn/alienated (no friends)	**Educational/Academic**
☐ Frequent nurse visits	☐ Dislikes school	☐ Low grades/GPA, Risk of failing
☐ Poor hygiene	☐ Attention seeking (+ / -)	☐ Does not complete work
☐ Vision concern (wears glasses?)	☐ Stealing/lying (Chronic/repeat)	☐ Frequently absent/late
☐ Other:	☐ Other:	☐ Other:

----------COUNSELOR USE ONLY----------

Date Seen:	**Counselor Name:**

SERVICES

☐ Harm to Self-Contract	☐ Overview of Grades	☐ SPA Assessment (suicide)
☐ Conflict Resolution Contract	☐ Overview of Discipline Record	☐ ARMS Assessment (threat)
☐ Bullying Contract	☐ Overview of Attendance/SARB	☐ Home visit
☐ Academic Contract	☐ Participant Criteria Reviewed	☐ Other:

Counselor notes and areas of concern from above:

Mark Prior or Current Service Involvement

☐ Dinuba Children's (DCS)	☐ Family Ed Center	☐ Speech Therapist
☐ Turning Point	☐ TCOE/SELPA	☐ Migrant Education
☐ District Nurse/Health	☐ Social Worker/CWS/CVRC	☐ Behavior Plan
☐ SRO	☐ School Counselor/Psychologist	☐ 504/IEP/ADA/Bright Start/Speech

Outgoing Referrals

☐ Special Services	☐ Family Ed Center	☐ Afterschool/Youth Programs
☐ SST	☐ Counseling (DCS, FSTC, VYSB, TYSB)	☐ Mentoring (YMI, BBBS, Girl Scouts)
☐ School Health Services	☐ Parenting	☐ Afterschool
☐ Foster, Homeless, or Migrant	☐ Basic Needs	☐ Youth Employment/Job Training
☐ Other	☐ Other:	☐ Other:

Family Contact Name: **Date:** **Type: Phone** ☐ **In-Person** ☐ **Meeting** ☐

Staff Contact Name: **Date:** **Type: Email** ☐ **Phone** ☐ **In-Person** ☐ **Meeting** ☐

----------FEC/SS/AYP USE ONLY----------

Date Received:	**Assigned to:**	**Initial client contact date:**
Services(s) Provided:		