



COJUSD Student Support Services Referral Form

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

CONFIDENTIAL

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	Withdrawn/alienated (no friends)	Educational/Academic	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

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

Date Seen:	Counselor Name:
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SERVICES					
<input type="checkbox"/>	Harm to Self-Contract	<input type="checkbox"/>	Overview of Grades	<input type="checkbox"/>	SPA Assessment (suicide)
<input type="checkbox"/>	Conflict Resolution Contract	<input type="checkbox"/>	Overview of Discipline Record	<input type="checkbox"/>	ARMS Assessment (threat)
<input type="checkbox"/>	Bullying Contract	<input type="checkbox"/>	Overview of Attendance/SARB	<input type="checkbox"/>	Home visit
<input type="checkbox"/>	Academic Contract	<input type="checkbox"/>	Participant Criteria Reviewed	<input type="checkbox"/>	Other:

Counselor notes and areas of concern from above:

Mark Prior or Current Service Involvement					
<input type="checkbox"/>	Dinuba Children's (DCS)	<input type="checkbox"/>	Family Ed Center	<input type="checkbox"/>	Speech Therapist
<input type="checkbox"/>	Turning Point	<input type="checkbox"/>	TCOE/SELPA	<input type="checkbox"/>	Migrant Education
<input type="checkbox"/>	District Nurse/Health	<input type="checkbox"/>	Social Worker/CWS/CVRC	<input type="checkbox"/>	Behavior Plan
<input type="checkbox"/>	SRO	<input type="checkbox"/>	School Counselor/Psychologist	<input type="checkbox"/>	504/IEP/ADA/Bright Start/Speech

Outgoing Referrals					
<input type="checkbox"/>	Special Services	<input type="checkbox"/>	Family Ed Center	<input type="checkbox"/>	Afterschool/Youth Programs
<input type="checkbox"/>	SST	<input type="checkbox"/>	Counseling (DCS, FSTC, VYSB, TYSB)	<input type="checkbox"/>	Mentoring (YMI, BBBS, Girl Scouts)
<input type="checkbox"/>	School Health Services	<input type="checkbox"/>	Parenting	<input type="checkbox"/>	Afterschool
<input type="checkbox"/>	Foster, Homeless, or Migrant	<input type="checkbox"/>	Basic Needs	<input type="checkbox"/>	Youth Employment/Job Training
<input type="checkbox"/>	Other	<input type="checkbox"/>	Other:	<input type="checkbox"/>	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:		