Clear form

Family Resource Center
CVESD/SUHSD School Referral Form 2020-21

540 G Street, Chula Vista, CA 91910 | www.ChulaVistaCC.org | 619.427.2119

Complete and Send | info@chulavistacc.org | Fax 619.427.6954
You will be notified of receipt within **2 work days | Contact Us 619.427.2119**

Referral Date:_____

1) Is the student in danger or at risk of harming self or others? ◯ No ◯ Yes (If Yes, as required per district protocol for risk-assessment, contact your school's psychologist and/or a trained staff member for assistance with active risk). CVCC is NOT able to accept referrals in which a student is actively at risk.

2) Indicate recommended time frame to contact family to set up an appointment
◯ Within 1 week (routine) ◯ Within 2-4 days (urgent) ◯ Within 24 hours/1 work day (emergency)

3) Was verbal consent for services given by the parent(s)/legal guardian(s)? ☐ Yes ☐ No – If no, contact family to get verbal consent OR explain special circumstance for not getting verbal consent.

School Referring Party Information (FRC staff to contact and to provide case status update)

Staff Name: _____ Email: _____

Staff Title: _____ School: _____ Phone _____

Family Information

Student Name: _____

Date of Birth: _____ Grade: _____ Insurance Provider: _____

Parent(s) Name*: _____ _____

Home Phone: _____ Cell/Alternate Phone: _____

Email: _____ Preferred Language: _____

Home Address :_____

Best time to contact family: ☐ Morning ☐ Mid-Day ☐ Afternoon ☐ Evening

* **Please indicate if there is anyone we are NOT to talk to /contact:** _____

Please provide detailed reason for sending referral:

Please state what actions/steps have already been taken by parent or school: