Clear form

# Family Resource Center
# CVESD/SUHSD School Referral Form 2021-22

**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**:_____ **Is this a mental health urgency: No__ Yes__**

**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**: