

E-mail as attachment to
Cindy_Engbretsen@pvusd.net
OR Fax (728-6931) OR
Pony to:
PVHS Healthy Start -
Attention: Cindy
Engbretsen

PVUSD Student Services - Healthy Start Program
PV High Resource Center
Referral Form

**** This Form is
now 2-sided! ****

Tel: (831) 728-7893 Fax: (831) 728-6931

WE WANT TO RESPOND TO THIS REFERRAL AS QUICKLY AS POSSIBLE. INCOMPLETE REFERRAL FORMS WILL RESULT IN UNNECESSARY DELAYS FOR A STUDENT IN NEED.

PLEASE HELP US BY COMPLETING as much INFORMATION as possible BELOW:

Name of Student _____ D.O.B. ___/___/___ Date of Referral: ___/___/___

School _____ Grade _____ ID# _____

MDT
Rev.
Date: _____

To:
 AP
 BU
 CC
 D&A
 FSA
 Guide
 Nurse
 Psych
 Pvpssa
 SIT
 SSHS
 OCSafe
 YS
 Other

Referring Person: _____
Position:
 _____ Teacher
 School Nurse/Health Clerk
 Office, Custodial, Security Staff
 Coach
 Counselor
 Administrator
 Other: _____

Is it OK to inform the student that you
made the Referral?
 Yes
 No

Student
Participates in the
Migrant Ed
Program?
 Yes
 No
 Don't
Know

Student's Language: Spanish only
 English Bilingual Sp/Eng.
 Other: _____

Parents or Guardian's
Primary Language:
 English Spanish
 Other: _____

Parent(s) or Guardian's Names:
 Mother: _____
 Father: _____
 Guardian: _____

Student lives with: Address: Telephone Numbers:
 Mother _____ (H)_____ (W/C)_____
 Father _____ (H)_____ (W/C)_____
 Guardian _____ (H)_____ (W/C)_____
 Currently homeless (Please provide *as much information as possible*, i.e., "kicked out of the house," staying with relatives, living on the street, staying in a shelter, "didn't like" foster care home, etc.):

Student wants (agrees to/is seeking) counseling.
MARK ONE: Student consents declines to give permission to contact his/her parent
If parent/guardian **has not been contacted**, please state reason why not: _____

***** **STUDENT'S HEALTH INSURANCE** *****

(This information is crucial for prompt assignment of student to health &/or counseling services).

- Medi-Cal None
- Healthy Families
- Healthy Kids
- Private Insurance (Plan Name) _____ (Blue Cross, RF Kennedy...)
Policyholder's name, if known (typically a parent): _____
- Student Does Not Know: if s/he has health insurance or not name of the Insurance Plan

Student's Regular Doctor or Clinic:

- _____ Doctor's Name or Practice Group (i.e., Pediatric Med Grp, Capitola Peds
- Salud Para La Gente Clinica del Valle Planned Parenthood
- Other: _____
- Student Does Not Know If S/he has a Doctor
- Maybe has a Doctor; s/he (a) doesn't remember name; (b) It has been a long time since his/her last office visit

Please describe the Reason for the Referral:

Also, please check all items below that apply:

Health Needs:

- Physical Exam
- Dental Care
- Pregnancy
- Frequent physical complaints / visits to School Health Office
- Supervision for medication compliance
- Sudden weight loss/gain
- Fatigue/sleepiness
- Unexplained injuries
- Other Health (please specify)

Social Needs:

- Recent loss (Death/divorce)
- Economic/housing problems
- Family conflict/concerns
- Substance abuse – student
- Substance abuse – member(s) of family
- Suspected gang involvement
- Domestic violence
- Recent immigrant
- Other: (please specify)

Behavior Observed:

- Withdrawn
- Anxious/fearful
- Hostile/aggressive/fighting
- Low self-image
- Self-Destructive/Suicidal
- Sexual acting-out
- Steals or destroys property
- Apathy/low motivation
- Runaway/homeless/"couch surfing" (** SIT **)
- Other: (please specify)

Educational Needs:

- refer to school administration for possible need for SST meeting

Agencies or services involved, previously & currently. **Please mark all known &/or that apply:**

- School Health Office/Nurse School Psychologist SELPA: circle all that apply: had SST/ has IEP/in SDC or RSP
- Guidance Counselor Safe Schools/SAP Counselor SARB'd **Healthy Start/Res. Ctr.:** i.e.FSA
- Foster Care **** SIT**** PVPSA Drug & Alcohol Cal-Safe Cath Charities, Youth Svcs, Defensa