

# REFERRAL: *To Mental Health programs, SCOE / ED, or ICC*

Date \_\_\_\_\_

Student \_\_\_\_\_ Nickname \_\_\_\_\_  Male  Female

Birthdate \_\_\_\_\_ Grade level \_\_\_\_\_ Teacher \_\_\_\_\_

District of residence \_\_\_\_\_ School \_\_\_\_\_

Case coordinator contact information: Name \_\_\_\_\_

Address \_\_\_\_\_

Phone/voicemail \_\_\_\_\_ Email \_\_\_\_\_

Parent/guardian name(s) \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Home primary language \_\_\_\_\_

Student's primary disability (check one):  S/L  SLD  ED  SH  Other \_\_\_\_\_

Current educational program:  100% regular ed  RSP  SDC  Home/Hospital

District alternative ed  Opportunity school  Reduced day  NPS  Independent Study

Court school  Home schooling  Not in school  Other \_\_\_\_\_

The IEP team is making a referral for \_\_\_\_\_

Date of parent meeting to discuss referral \_\_\_\_\_ Parent reaction to referral:  Support  Disagree  Ambivalent

### District modifications and their effectiveness

*Identify where information is located in referral packet (i.e., cover letter, page number of psycho-educational report, IEP, counseling report form, etc.)*

Changes in classroom program \_\_\_\_\_

Curriculum modifications \_\_\_\_\_

Behavior plan (note if Hughes Bill plan) \_\_\_\_\_

Schedule and program changes \_\_\_\_\_

Staffing changes (e.g., teacher/aide) \_\_\_\_\_

Other \_\_\_\_\_

### Other current information

Gang related issues .....  Yes .....  No .....  Concerned

CPS .....  Yes .....  No .....  Concerned

Substance abuse\* .....  Yes .....  No .....  Concerned

\*If yes, indicate: .....  Alcohol .....  Drugs

NBRC.....  Yes .....  No

Incarceration .....  Yes .....  No

Probation .....  Yes .....  No

Dependent of court.....  Yes .....  No

State adoption youth .....  Yes .....  No

Recent hospitalization(s) \_\_\_\_\_

LCI/Group home \_\_\_\_\_

Other agency involvement \_\_\_\_\_

Therapeutic Services ...  Yes ...  No

Provider name/phone \_\_\_\_\_

Provided by:  Sonoma County Mental Health

Community service agency

Participates in non-IEP therapy services

Current SCMHS Referral

Name/phone of probation officer \_\_\_\_\_

Name/phone of social worker \_\_\_\_\_

If yes, adopted from what county? \_\_\_\_\_

# **DOCUMENTATION:** *Required for Mental Health Referral*

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Student's Name \_\_\_\_\_ Today's Date \_\_\_\_\_

In order to ensure that assessments and other information are as useful as possible in determining the need for mental health services and the level of services needed, the following items must be submitted to Sonoma County Mental Health.

- 1. Mental Health referral form.
- 2. Cover letter written by school psychologist/qualified educational staff that addresses:
  - a. Description of problem behaviors/characteristics (such as attention, impulsivity, aggressive behavior, anxiety, depression, poor social skills);
  - b. Whether emotional/behavioral characteristics impede student from benefiting from educational services;
  - c. If they are significant as indicated by their rate of occurrence and intensity;
  - d. If they are associated with a condition that cannot be described solely as a social maladjustment or temporary adjustment problem, and cannot be resolved with short-term counseling;
  - e. If student's functioning, including cognition, is at a level sufficient to enable the student to benefit from mental health services; and
  - f. Student's progress or lack thereof toward IEP goals in the past year, due to mental health needs.
- 3. Most recent full IEP with current goals, including social/emotional goals relevant to this referral.
  - Any relevant addendums since the most recent full IEP.
  - Specific statement on IEP or IEP amendment form that IEP team is referring student for an AB3632 assessment.
- 4. Statement on IEP that team has completed and reviewed the Mental Health Pre-Referral Activities **(attach Pre-Referral Activities form to IEP or IEP amendment)**.
- 5. Copy of parent's consent for mental health referral, for release and exchange of information between educational and mental health agencies, and for observation of student by mental health professionals in educational setting.
- 6. Current assessment reports in all areas of suspected disabilities, especially report by school psychologist.
- 7. Other relevant assessments/reports, if available (such as hospital discharge summary, Diagnostic Center report, behavioral report, counseling summary).
- 8. Achenbach Behavioral Checklist or Behavior Assessment System for Children, Second Edition (BASC-2) within three months of referral. *Note that, beginning in Fall 2009, only the BASC-2 will be accepted.*
- 9. Hughes Bill or Positive Behavior Support Plan plus report on its effectiveness (as appropriate; behavior plan is required for students who demonstrate externalizing behaviors).
- 10. Youth Services Information form (preferred) or Health & Developmental History.

## Mental Health Pre-Referral Activities

*Please address each area.*

**REQUIRED  
ATTACH TO IEP**

Student Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

- 1) For students who have deficits in social skills as one of their chief characteristics, please indicate prior school interventions to address this area.

Type of service: \_\_\_\_\_ Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

Student's response to service or where information is located:

- 2) For students who have unruly, defiant and/or aggressive behavior as one of their chief characteristics, please indicate prior school interventions to address this area.

Type of service: \_\_\_\_\_ Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

Student's response to service or where information is located:

- 3) Describe any other counseling services provided within the past year by school staff.

Type of service: \_\_\_\_\_ Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

Student's response to service or where information is located:

- 4) Describe any therapeutic mental health interventions the student received outside of the school setting within the past year.

Type of service: \_\_\_\_\_ Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

Student's response to service or where information is located:

- 5) Describe other services the student/family received such as parent counseling and training, social work, or psychological services.

Type of service: \_\_\_\_\_ Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

Student's response to service or where information is located:

- 6) If services were determined not to meet the needs of the student, explain why.

- 7) Describe any transitory crises in the pupil's life which are negatively affecting his/her educational adjustment in addition to the long-term pervasive problems described in the accompanying psycho-educational report.

# Observation Questionnaire

OPTIONAL

To be completed by School Psychologist with input from relevant sources

Student Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

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This questionnaire is designed to provide mental health with a general sense of the youth's presentation. Please check all that apply. Feel free to write in any clarifying comments.

- 1. Shows ego strength (except in school situation). Adequate self concept.
- 2. Pervasively poor self-concept. Blames self for problems.
- 3. Tends to be independent to the degree of disregarding adult authority.
- 4. Overly dependent or impulsively defiant. (Circle which is applicable.)
- 5. Lacks appropriate guilt or remorse.
- 6. Generally anxious or fearful; mood swings from depression to high activity.
- 7. Blames others for his/her problems, but otherwise is reality oriented.
- 8. Frequent denial and confusion. Distorts reality.
- 9. Has intact peer relationships with those having same social values – may be egocentric, self-centered with shallow relationships.
- 10. Peer relationships pervasively poor, short-lived.
- 11. Member of a subculture group that is antisocial (“street smart”/gangs).
- 12. Difficulty establishing or maintaining group membership.
- 13. Skilled at manipulating others. Behavior is goal driven and often predictable.
- 14. Often alienates others by intensity of need for attention or bizarreness of idea or behavior.
- 15. Conflicts are primarily with authority figures, “power struggles.”
- 16. Conflict and tension characterize almost all relationships.
- 17. Social problems generally situation specific.
- 18. Pervasive social problems at school, home and in community.

# Observation Questionnaire

OPTIONAL

To be completed by School Psychologist with input from relevant sources

Student Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

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- 19. Tends to dislike school except for social contact. May be truant; rebels against rules and structure.
- 20. School is a source of confusion and anxiety. Often responds positively to structure in the educational program.
- 21. Frequently avoids school achievement, even in areas of competence.
- 22. Achievement often uneven. Attention, concentration impaired by anxiety.
- 23. Productivity is inconsistent – may have areas of high output when motivated.
- 24. Not able to achieve academically, socially or vocationally because of the emotional disturbance.
- 25. Behavior is under operant control – understandable and goal motivated although disturbing.
- 26. Behavior beyond student's control; bizarre, non-goal oriented and unpredictable.
- 27. Behavior responsive to good quality planned behavioral intervention.
- 28. Behavioral interventions produce minimal or no behavioral changes.
- 29. Behaviors are situation specific – may have markedly different responses in different situations with different people.
- 30. Behaviors are pervasive across situations and individuals.

SONOMA COUNTY SPECIAL EDUCATION LOCAL PLAN AREA  
REFERRAL FOR MENTAL HEALTH ASSESSMENT  
(AB3632, Chapter 26.5 of the Government Code)

STUDENT: \_\_\_\_\_ DOB: \_\_\_\_\_  
DISTRICT: \_\_\_\_\_ SCHOOL: \_\_\_\_\_

Dear Mr./Mrs./Ms.: \_\_\_\_\_

We recommend a mental health assessment for your child to determine whether mental health services are needed for your child to benefit from his/her special education program.

This need for mental health services is determined by Sonoma County Mental Health. Your written permission is necessary to

- 1) Refer your child to Mental Health for assessment and determination of need for services
- 2) Exchange of confidential information between Mental Health and the school
- 3) Allow Mental Health personnel to observe your child in school if necessary

If you have any questions, please contact:

\_\_\_\_\_  
Name and Title

\_\_\_\_\_  
School Phone

PARENT CONSENT

- 1) I give consent for my child \_\_\_\_\_  
to be referred to Sonoma County Mental Health for assessment.
- 2) I give consent for my child's school district and Sonoma County Mental Health to release and exchange confidential information concerning my child.
- 3) I give consent for Sonoma County Mental Health to observe my child in school if necessary.
- 4) I give permission for \_\_\_\_\_  
Name and Title

\_\_\_\_\_  
Address Phone  
to release confidential information to the school district and to Sonoma County Mental Health

\_\_\_\_\_  
Signature of Parent or Guardian Date

No educational placement or service, including mental health services, will result from this assessment without the parent's/guardian's expressed written permission.