



# College Community Services Referral Form

## Child Referral Form for Counseling Services

Client Information	Date of Referral: <b>(required)</b>		Cerner Number: _____ <b>(office use only)</b>	
	Referral Agency: <input type="checkbox"/> School <input type="checkbox"/> Primary Physician <input type="checkbox"/> Probation <input type="checkbox"/> Self/Parent <input type="checkbox"/> Other _____			
	Contact Person at referral site:		Telephone:	
	Referral Type: <input type="checkbox"/> Call-in <input type="checkbox"/> Fax <input type="checkbox"/> Walk-in <input type="checkbox"/> Transfer/Other: _____			
	Name:		DOB:	Age:
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> TGI			
	Address:		City:	Zip Code:
	Telephone/Message Number:		Alternative Number:	
	Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other			
	Does the child have: <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Medi-Cal with Kern Family Health Care <input type="checkbox"/> Other/Private			
	Name of Parent:		Legal Guardian/ Foster Parent:	
	Parent Signature <b>(required)</b> :			
School Information	School Name:		Special Ed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Grade:
	Teacher:		Telephone:	Fax No:
	Other Agencies/Services Involved: <input type="checkbox"/> School Psychologist <input type="checkbox"/> AB/Wraparound <input type="checkbox"/> Kern Regional Center <input type="checkbox"/> Probation			
Reason For Referral (Please check appropriate)	<u>School/Work Performance</u> <input type="checkbox"/> Tardy/poor attendance <input type="checkbox"/> Poor work performance <input type="checkbox"/> Learning disability <input type="checkbox"/> Low interest/motivation <input type="checkbox"/> Poor Concentration <input type="checkbox"/> Incomplete work <input type="checkbox"/> Numerous fights <input type="checkbox"/> Short attention span <input type="checkbox"/> Suspensions	<u>Behavior/Mood</u> <input type="checkbox"/> Aggressive/angry/hits <input type="checkbox"/> Short temper <input type="checkbox"/> Impulsive <input type="checkbox"/> Low self-worth <input type="checkbox"/> Seeks attention <input type="checkbox"/> Steals/lies <input type="checkbox"/> Withdrawn/Isolative <input type="checkbox"/> Anxious/nervous <input type="checkbox"/> Sad/depressed/ <input type="checkbox"/> Erratic behavior <input type="checkbox"/> Disrupts others <input type="checkbox"/> Daydreams <input type="checkbox"/> Paranoia <input type="checkbox"/> Delusions <input type="checkbox"/> Hallucination <input type="checkbox"/> Self-Harming behavior <input type="checkbox"/> Alcohol/Drug Use	<u>Home situation</u> <input type="checkbox"/> Separation/Divorce <input type="checkbox"/> Step family <input type="checkbox"/> Foster Care <input type="checkbox"/> Adopted  <u>Social environment changes</u> <input type="checkbox"/> Deaths <input type="checkbox"/> Births <input type="checkbox"/> Family/friend moved <input type="checkbox"/> Housing issues <input type="checkbox"/> Frequent runaway <input type="checkbox"/> Pregnant <input type="checkbox"/> Financial issues <input type="checkbox"/> Legal issues	

Other Information: \_\_\_\_\_



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**Identified Risk**

1. **Has the individual been a danger to him/herself or to others in the last 90 days?**  
 Yes  No  Unknown
2. **Does individual currently have any thoughts, plans or intent to commit suicide?**  
 Yes  No  Unknown
3. **Does individual currently have any homicidal thoughts, plans or intent?**  
 Yes  No  Unknown

**OFFICE USE ONLY**  
**CONTACT ATTEMPT:**

1<sup>ST</sup> \_\_\_\_\_ **RESPONSES** \_\_\_\_\_ **INITIAL** \_\_\_\_\_  
 2<sup>ND</sup> \_\_\_\_\_ **RESPONSES** \_\_\_\_\_ **INITIAL** \_\_\_\_\_  
 3<sup>RD</sup> \_\_\_\_\_ **RESPONSES** \_\_\_\_\_ **INITIAL** \_\_\_\_\_

**Letter sent** \_\_\_\_\_

THIS TRANSMISSION CONTAINS CONFIDENTIAL AND PRIVILEGED HEALTH INFORMATION THAT IS PROTECTED FROM MISUSE AND UNAUTHORIZED DISCLOSURE BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, THE REGULATIONS PROMULGATED THEREUNDER, AND OTHER APPLICABLE STATE LAWS (COLLECTIVELY, "THE LAWS"). VIOLATION OF THE LAWS MAY RESULT IN CIVIL AND/OR CRIMINAL PROSECUTION AND/OR THE IMPOSITION OF MONETARY PENALTIES. THE INFORMATION CONTAINED IN THIS TRANSMISSION IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY TO WHICH IT IS ADDRESSED. IF THE READER OF THIS OF THIS MESSAGE IS THE INTENDED RECIPIENT, OR THE EMPLOYEE, OR AGENT RESPONSIBLE FOR THE DELIVERING THE MESSAGE TO THE INTENDED RECIPIENT YOU ARE HEREBY NOTIFIED THAT ANY USE, DISCLOSURE, DISSEMINATION, DISTRIBUTION OR COPYING OF THIS TRANSMISSION AND THE INFORMATION CONTAINED HEREIN ARE STRICTLY PROHIBITED AND UNLAWFUL. IF YOU HAVE RECEIVED THIS TRANSMISSION IN ERROR, PLEASE NOTIFY THE PRIVACY OFFICER OR ASPEN EDUCATION GROUP IMMEDIATELY BY CALLING TOLL-FREE (888) 97-ASPEN AND KINDLY RETURN THE ORIGINAL TRANSMISSION VIA THE U.S. POSTAL SERVICE ADDRESSED TO: ASPEN EDUCATION GROUP, 1777 CENTER COURT DRIVE, SUITE 300, CERRITOS, CA 90703, ATTN: PRIVACY OFFICER.

**OFFICE USE ONLY**

**Outcome Results:**

**Assessment Date:** \_\_\_\_\_ **Referring Party Informed:**  Yes  No **Date:** \_\_\_\_\_

**Qualified**      **Not Qualified**

**CCS Wasco Clinic**  
29325 Kimberlina Rd.  
Wasco, CA 93280  
**Tel: 661-758-4029**  
Fax: 661-758-0891

**CCS Taft Clinic**  
1021 4th Street, Suite B  
Taft, CA 93268  
**Tel: 661-765-7025**  
Fax: 661-765-7045

**CCS Tehachapi Clinic**  
113 East F Street  
Tehachapi, CA 93561  
**Tel: 661-822-8223**  
Fax: 661-823-9347

**CCS Lake Isabella Clinic**  
2731 Nugget Ave.  
P.O. Box 2632  
Lake Isabella, CA 93240  
**Tel: 760-379-3412**  
Fax: 760-379-5332

**CCS Mojave Clinic**  
16940 Hwy. 14, Suites C-J  
Mojave, CA 93501  
**Tel: 661-824-5020**  
Fax: 661-824-5026

**CCS Ridgecrest Clinic**  
1400 N. Norma St., Ste. 127-133  
Ridgecrest, CA 93555  
**Tel: 760-499-7406**  
Fax: 760-499-7479