College Community Services Referral Form
Child Referral Form for Counseling Services

Client Information

Date of Referral: (required)	Cerner Number: ___________________ (office use only)
Referral Agency: ☐ School ☐ Primary Physician ☐ Probation ☐ Self/Parent ☐ Other _____________________	
Contact Person at referral site:	Telephone:
Referral Type: ☐ Call-in ☐ Fax ☐ Walk-in ☐ Transfer/Other:_____________________________	
Name:	DOB: / Age:
Sex: ☐ Male ☐ Female ☐ TGI	
Address:	City: / Zip Code:
Telephone/Message Number:	Alternative Number:
Preffered Language: ☐ English ☐ Spanish ☐ Other	
Does the child have: ☐ Medi-Cal ☐ Medi-Cal with Kern Family Health Care ☐ Other/Private	
Name of Parent:	Legal Guardian/ Foster Parent:
Parent Signature (required):	

School Information

School Name:	Special Ed: ☐ Yes ☐ No	Grade:
Teacher:	Telephone:	Fax No:
Other Agencies/Services Involved: ☐ School Psychologist ☐ AB/Wraparound ☐ Kern Regional Center ☐ Probation		

Reason For Referral (Please check appropriate)

School/Work Performance	Behavior/Mood	Home situation
☐ Tardy/poor attendance	☐ Aggressive/angry/hits	☐Separation/Divorce
☐ Poor work performance	☐ Short temper	☐Step family
☐ Learning disability	☐ Impulsive	☐Foster Care
☐ Low interest/motivation	☐ Low self-worth	☐Adopted
☐ Poor Concentration	☐ Seeks attention	
☐ Incomplete work	☐ Steals/lies	**Social environment changes**
☐ Numerous fights	☐ Withdrawn/Isolative	☐Deaths
☐ Short attention span	☐ Anxious/nervous	☐Births
☐ Suspensions	☐ Sad/depressed/	☐Family/friend moved
	☐ Erratic behavior	☐Housing issues
	☐ Disrupts others	☐Frequent runaway
	☐ Daydreams	☐Pregnant
	☐ Paranoia	☐Financial issues
	☐ Delusions	☐Legal issues
	☐ Hallucination	
	☐ Self-Harming behavior	
	☐ Alcohol/Drug Use	

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:

1ST_______________ RESPONSES__________________________ INITIAL_________

2ND______________ RESPONSES____________________________INITIAL_________

3RD______________ RESPONSES____________________________ INITIAL________

Letter sent____

THIS TRANSMISSION CONTAINS CONFIDENTIAL AND PRIVILEDGED HEALTH INFORTMATION 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 RESPOSIBLE FOR THE DELIVERING THE MESSAGE TO THE INTENDED RECIPIENT YOU ARE HEREBY NOTIFIED THAT ANY USE, DISSCLOSSURE, 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.

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Outcome Results:

Assessment Date: _______________ Referring Party Informed: ☐Yes ☐No Date: ______________

Qualified **Not Qual ified**

CCS Wasco Clinic	CCS Taft Clinic	CCS Tehachapi Clinic	CCS Lake Isabella Clinic	CCS Mojave Clinic	CCS Ridgecrest Clinic
29325 Kimberlina Rd.	1021 4th Street, Suite B	113 East F Street	2731 Nugget Ave.	16940 Hwy. 14, Suites C-J	1400 N. Norma St., Ste. 127-133
Wasco, CA 93280	Taft, CA 93268	Tehachapi, CA 93561	P.O. Box 2632	Mojave, CA 93501	Ridgecrest, CA 93555
			Lake Isabella, CA 93240		
Tel: 661-758-4029	Tel: 661-765-7025	Tel: 661-822-8223	Tel: 760-379-3412	Tel: 661-824-5020	Tel: 760-499-7406
Fax: 661-758-0891	Fax: 661-765-7045	Fax: 661-823-9347	Fax: 760-379-5332	Fax: 661-824-5026	Fax: 760-499-7479