Family Service Agency of Burbank
Counseling ~ Educating ~ Preventing ~ Advocating
Since 1953

Elementary / Middle / High School Referral Form

School:_____ Date:_____

Referred By:_____

Student:_____ Age:_____ Grade_____

Parents/Guardians:_____

Address:_____

Home/Work/Cell Phone #:_____

1) Why are you recommending this student for this program?_____
_____
_____
_____
_____

2) Does this student receive special education services?_____
Has an IEP meeting occurred? Yes_____ No_____ Date_____

3) Is the district aware of any information regarding this student receiving previous psychiatric care?
Any hospitalizations?_____ If so, when?_____

4) Survey completed/signed by _____ Schedule provided if applicable _____

Please note a referral is *incomplete* if it does not have a signed survey and schedule (if applicable)

Contact Persons:

Taylor Foxhall, LMFT - Director, Care Centers and High School Based Counseling

Alex Walters, LMFT – Director, Middle Schools/Alternative High Schools

For FSA office purposes:

____School Based ____Agency ____Outside Provider ____Pausing Referral ____Declining

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To be filled out by the referring party in a position to observe the student

Minor Client's Name _____**Date**_____

Child's Grade _____**Child's DOB** _____**Child's Sex** _____

Completed By _____

School Attending_____

To your knowledge **Please rate the degree to which your child has experienced the following concerns in the past 30 days.**	Not At All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. He/She has not been attending school or has difficulty getting to class/tardies	0	1	2	3	4	5
2. He/She has difficulty at times being truthful	0	1	2	3	4	5
3. He/She displays of high energy physically	0	1	2	3	4	5
4. He/She has physically harmed himself/herself	0	1	2	3	4	5
5. He/She has expressed thoughts of self-harm	0	1	2	3	4	5
6. He/She has feelings of loneliness and helplessness	0	1	2	3	4	5
7. He/She is isolating himself/herself	0	1	2	3	4	5
8. He/She has expressed of intense fear or anxiety	0	1	2	3	4	5
9. He/She has expressed worry of negative/bad events	0	1	2	3	4	5
10. He/She has seems sad or depressed	0	1	2	3	4	5
11. He/She has difficulty falling asleep, staying asleep, or nightmares	0	1	2	3	4	5
12. He/She has difficulty maintaining healthy eating habits	0	1	2	3	4	5
13. He/She has verbal conflicts with others	0	1	2	3	4	5
14. He/She has physical conflicts with others	0	1	2	3	4	5
15 He/She has difficulty following rules and/or directions	0	1	2	3	4	5
16. He/She has negative impulsive behavior	0	1	2	3	4	5

17. He/She has used illicit substances	0	1	2	3	4	5
18. He/She has been involved with law enforcement	0	1	2	3	4	5
19. He/She has difficulty paying attention	0	1	2	3	4	5
20. Other	0	1	2	3	4	5

Referring Party's Signature:_____ Date:_____