STAGG HIGH SCHOOL • WELLNESS CENTER

1621 Brookside Road, Room E2
Stockton, CA 95207 • 209/933.7445 x8485

REFERRAL FORM

Student's Name (*Last, First*):	Student's ID#:
Student's School Site (*check one*): ❒ Stagg High School ❒ Stockton Public Safety Academy ❒ Pacific Law Academy	
Referral Source (*check one*): ❒ Self ❒ Referred By: _____ Date of Referral:	Was student informed of referral? ❒ Yes ❒ No Was parent/guardian informed of referral? ❒ Yes ❒ No

Check all items that apply

Perceived Strengths:	***Risk Factors:***	***Reason For Referral:***
○ Able to communicate clearly ○ Articulates feelings ○ Avoids conflict/trouble ○ Caring ○ Completes class work ○ Cooperates well ○ Determined ○ Empathetic ○ Follows instructions ○ Gets along with others ○ Listens ○ Meets academic goals ○ Negotiates/Compromises ○ Organized ○ Plans well ○ Problem solves ○ Respectful ○ Responsible ○ Sense of humor ○ Sets goals ○ Social ○ Team player ○ Volunteers or helps others	○ Aggressive ○ Bullying/Being bullied by others ○ CPS contact ○ Disruptive behavior (i.e. rebellious, defiant) ○ Economically disadvantaged ○ Frequent relocation/mobility ○ Homeless ○ Illness or death of family/friend ○ Isolation from peers ○ Low self-esteem ○ Negative peer pressure ○ Out of home placement ○ Parent divorce/separation ○ Poor communication ○ Poor hygiene ○ Siblings in trouble ○ Suicidal thoughts ○ Suspected parent dysfunction ○ Suspected substance use	○ Absenteeism ○ Academic Issues ○ Aggressive/Assaultive Behavior ○ Anger Management ○ Bullying (Victim/Perpetrator) ○ Depression/Sadness ○ Family Problems ○ Gang Involvement ○ Grief/Death ○ Hearing Screening ○ Medical concern/Frequent somatic complaints ○ Neglect/Abuse ○ Non-productive/Not performing to ability ○ Parent/Youth Issues ○ Physical Abuse ○ Self-Harm ○ Sexual Abuse ○ Substance Use/Abuse ○ Suicidal Threats/Behaviors ○ Vision Screening ○ Withdrawn/Isolated

Please provide a brief description of the problem, including observations and concerns:

Submit to the Wellness Center Coordinator, Rm. E2, or place in box in staff lounge.

To be completed by Wellness Center Staff

Parent/Guardian Consent Form on file? ❒ Yes ❒ No If not, follow-up completed by/on: _____
Date Received: _____ Date Referred to Provider: _____ By: _____

Provider/Services Referred:

❒ ***Child Abuse Prevention Council (CAPC):*** ❒ PHQ-9 Assessment ❒ BFFD ❒ CAST

❒ ***Community Medical Center (CMC):*** ❒ Smoking Cessation ❒ Brief Intervention/Substance Use

❒ ***Delta Health Care:*** ❒ Intern: _____ ❒ Therapist

❒ ***SJC Probation-Crossroads Program:*** ❒ Community Resources ❒ Counseling ❒ Skill Building

❒ ***SUSD Mental Health & Behavior Support Services:*** ❒ Clinician

❒ ***SUSD School Nurse:*** ❒ Vision ❒ Hearing ❒ Other: _____

❒ ***Other Services:*** _____

To be completed by provider

Date Received: _____ Date of 1st Contact with Student: _____

Did student decline services? ❒ Yes ❒ No If so, why? _____

Initial Assessment/Notes: _____
_____
_____

Progress Notes: _____
_____
_____

Recommendations/Additional Referrals: _____
_____
_____

Did student complete program? ❒ Yes ❒ No Completion/Closing Date: _____ If not, why? _____

Final Comments: _____
_____
_____

Provider's Signature: _____ Date: _____

****Once student has completed program or been closed out, please return completed form to the Wellness Center Coordinator. Thank you!***