546 G Street, Chula Vista CA 91910
Ph. (619) 427-2119

Family Resource Center
CVESD/SUHSD School Referral Form 2017-18

Revised 8/24/17

Complete form and send to the **CVCC Administration Office,** fax (619) 427-6954 or email **info@chulavistacc.org**
If you have any questions or additional information, please call (619) 427-2119.

If you do NOT receive notification of receipt of this referral within 2 work days, please contact us at (619) 427-2119.

Referral Date: _____

1) Is student in danger or at risk of harming self or others? ☐ **No** ☐ **Yes** ***(As required by district's protocol for risk-assessment, contact your school's psychologist and/or a trained staff member for assistance with active risk).***
CVCC/FRCs are NOT able to accept referrals in which a student is actively at risk.

2) **Indicate recommended time frame to contact family to set up an appointment:**
☐ Within 1 week (routine) ☐ Within 2-4 days (urgent) ☐ Within 24 hours/1 work day (emergency)

3) Was verbal consent for services given by the parent(s)/legal guardian(s)? ☐ **Yes** ☐ **No – *If no***, *please contact family to get verbal consent OR explain below special circumstance for not getting verbal consent.*

School Referring Party Information: (for FRC staff to contact you and to provide case status update)

School Staff Name: _____ Email: _____

School: _____ Phone Number: _____

Family Information:
Student Name: _____

Date of Birth: _____ Grade: _____ Insurance Provider: _____

Parent(s) Name*: _____ _____

Home Phone: _____ Cell/Alternate Phone: _____

Email: _____ Preferred Language: _____

Home Address: _____

Best time to contact family: Morning Mid-Day Afternoon Evening

* **Please indicate if there is anyone we are NOT to talk to /contact:** _____

Please provide detailed reason for sending referral:

Please state what actions/steps have already been taken by parent or school: