ECS Wellness Center
Mental Health Services Referral

Date of Request:_____

Student's Last Name:_____ Student's First Name:_____ DOB:_____

Age:_____ Gender (circle one): F / M / NB Grade:____ Race/Ethnicity:_____ Tribal Affiliation:_____

School:_____Student phone number:_____ Consent to text: ☐ yes Initials:_____

_____I consent to my student being taken out of academic classes if necessary. (We will attempt non-academic first)

Interpretation services needed for Student or Family: ☐ Yes ☐ No Language Spoken:_____

Ed Services: ☐ English Learning ☐ 504 ☐ IEP ☐ None

Insurance: ☐ Medi-Cal ☐ Partnership ☐ Private ☐

I understand the conditions described above and consent to my child's participation in the Wellness Center.

Name of Caregiver (Legal Guardian): _____

Name of Insurance Provider: _____

Medi-Cal #/Insurance Card #: _____

Caregiver Signature: _____ Date: _____

Home Phone:_____ Cell Phone:_____

Home Address:_____ City:_____ Zip:_____

Reason for referral: (Please include any known services or interventions, past or present)

Best day/time to pull youth:_____

Student is: ☐ Foster Care ☐ Homeless Has the District Liaison been contacted? ☐ Yes ☐ No

Referral Source:

Name:_____ School Site:_____

updated 6.3.2024

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Phone:_____ Administrator:_____

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