



# North County Lifeline, Inc.

Confidential Student Information

Fax to:  
EPSDT Counseling Intake  
**760-631-0778**

School:  
Phone:

## CUSD ADD UP Substance Abuse Group Referral Form

### Student information

First name <i>(Legal name)</i>	Middle	Last name	Age	M/F	Date of Birth
Social Security number*	Grade	Teacher/Counselor	Ethnic Origin		
Street address			<input type="checkbox"/> White	<input type="checkbox"/> Pacific Islander	
			<input type="checkbox"/> Hispanic	<input type="checkbox"/> Vietnamese	
City			<input type="checkbox"/> Black	<input type="checkbox"/> Native American	
			<input type="checkbox"/> Filipino	<input type="checkbox"/> Middle Eastern	
State			<input type="checkbox"/> Asian	<input type="checkbox"/> Other:	
CA			Zip code		
Parent/Guardian			Relationship to student		
Home phone Number			Work phone number		Mobile/other number

### Consent for treatment

In the case of a waitlist, parent/guardian gives permission to have another agency contact them.  Yes  No

**Has the parent/guardian given consent for North County Lifeline to contact them?**  Yes  No

Parent/guardian has been informed of mandatory family participation in family counseling?  Yes  No

Name of school personnel that spoke with the parent/guardian about counseling: \_\_\_\_\_

Date of consent: \_\_\_\_\_ Who did you contact? \_\_\_\_\_ Can parent/guardian be contacted at work?  Yes  No

Does the parent/guardian speak English?  Yes  No

Does the student speak English?  Yes  No

Primary language spoken in home:  English  Spanish

Paperwork requirements:  English  Spanish

<p><b>*Insurance Information (Please provide)</b></p> <p>Does the family have MediCal coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>MediCal/BIC Number: _____</p> <p>Does the family have Insurance Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>If yes, family is not eligible for counseling services, please refer to Primary Care Provider.</i></p> <p>Does the family have Healthy Families? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>If yes, family is not eligible for counseling services, please refer to HF Primary Care Provider.</i></p>	<p><b>Current or Previous Treatment (If known)</b></p> <p>Current/Previous Counseling: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What agency? _____</p> <p>Therapist: _____</p> <p>Is student on medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>List medication(s): _____</p>
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### Reasons to request mental health evaluation, please check all that apply

<input type="checkbox"/> Disruptive behavior	<input type="checkbox"/> Academic performance/ attendance	<input type="checkbox"/> Theft
<input type="checkbox"/> Inappropriate behavior	<input type="checkbox"/> Health problems	<input type="checkbox"/> Alcohol/substance abuse
<input type="checkbox"/> Anger outburst <input type="checkbox"/> Anger issues	<input type="checkbox"/> Financial problems	<input type="checkbox"/> Gang involvement
<input type="checkbox"/> Talks back <input type="checkbox"/> Fighting	<input type="checkbox"/> Death of a family member	<input type="checkbox"/> Domestic Violence in home
<input type="checkbox"/> Withdrawn/Isolates <input type="checkbox"/> Sad	<input type="checkbox"/> Family issues	<input checked="" type="checkbox"/> <b>Cutting**</b>
<input type="checkbox"/> Anxious <input type="checkbox"/> Moody	<input type="checkbox"/> *Divorce <input type="checkbox"/> *Separation	<input checked="" type="checkbox"/> <b>Suicidal ideations or attempts**</b>
<input type="checkbox"/> Social problems <input type="checkbox"/> Truancy	<i>*Will need both parents consent for services</i>	
<input type="checkbox"/> other:		

### Additional comments or concerns:

Referring Staff: \_\_\_\_\_ Position: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*Provide Rady's Behavioral Crisis Center 760-730-5900 and Access & Crisis Line 1-800-479-3339**