Calexico Unified School District

Calexico Family Resource Center
604 W. Birch Street / Hwy. 98 and Lacy Avenue
Calexico, CA 92231
☎ (760) 768-3905 768-3906

Community Referral Form

**** This Section to be Completed by Referring Agency **** Date of Referral:_____

PARTS I, II, AND COMMENTS MUST BE TYPED/SCHOOL SITES NEED SIGNATURE FROM PRINCIPAL/VP

I. Referral Source **Principal Signature: _____**

Referred by:___ School (specify):_____ Contact Name: _____
___ Community Agency:_____ Title:_____
___ Self / Other (specify):_____ Phone Number: _____

II. Client Demographics

Child/Client Name:_____ Age:_____ Birthdate:_____ ☐ Female, ☐ Male
Parent / Guardian:_____ Relationship to minor:_____ Grade: ____
Address:_____ Home Phone #:_____ Work Phone #: _____

Is family aware of referral: ☐ **Yes,** ☐ **No**., Educational Programs: ☐ LEP ☐ Special Ed. ☐ Migrant ☐ Other
Interventions: ☐ SST ☐ SARB ☐ COUNSELING ☐ TUTORING ☐ PARENT TRAININGS ☐ OTHER_____

III. Services Requested / Family Needs (check all that apply)

☐ Parenting Classes ☐ Anger Management ☐ Behavioral Health
☐ Pregnant Teen/Teen Parent Services ☐ Family Functioning ☐ Alcohol & Drug Counseling
☐ Social Services (Medi-Cal, Food Stamps, AFDC) ☐ Eye examination and or glasses
☐Uniforms/school supplies or clothes (homeless students) ☐ Other (Specify): _____

Comments / Observations: _____

_____

_____

_____

_____

****This Section to be completed by FRC Staff Only*****

IV. Referral Screening / Eligibility

Date of Intake / Assessment:_____ Case Number: _____ By Staff:_____

Services to be provided:	**Case Assigned to:**	**Family Goals / Objectives:**
☐ Anger Management Class	☐ Social Worker	1 _____
☐ Behavioral Health Referral	☐ Eligibility Worker	2 _____
☐ Information & Referral	☐ FRC Coordinator	
☐ ICDSS	☐ AFLP	
☐ Teen Pregnancy	☐ other_____	

Staff Comments: _____

_____

V. Discharged / Services not Provided due to:

☐ Family Non-Compliant, ☐ Client Refused Services, ☐ Moved out of Area, ☐ No other services needed Other:

_____