

**County of Orange Health Care Agency Behavioral Health Service  
Children and Youth Services  
Referral for Chapter 26.5/AB3632  
Mental Health Service**

Referring School District: \_\_\_\_\_ Referral Date: \_\_\_\_\_

Students Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Number Street Apartment

\_\_\_\_\_ City State Zip Code

Home Phone: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_  
Last First Middle

MOTHER \_\_\_\_\_  
(complete only if Number Street Apartment  
different then student's)

\_\_\_\_\_ City State Zip Code

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

FATHER \_\_\_\_\_  
(complete only if Number Street Apartment  
different then student's)

\_\_\_\_\_ City State Zip Code

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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School Site: \_\_\_\_\_ Phone: \_\_\_\_\_

Teacher's Name: \_\_\_\_\_ School Psychologist \_\_\_\_\_

Phone: \_\_\_\_\_

Current Special Education Services:  
\_\_\_\_\_  
\_\_\_\_\_

Other Agencies Involved (Social Services, Probation, Mental Health):  
\_\_\_\_\_  
\_\_\_\_\_

Date of IEP which resulted in referral: \_\_\_\_\_

Date of Proposed IEP relative to Assessment \_\_\_\_\_

Informed Consent \_\_\_\_\_

\_\_\_\_\_  
Parent's Signature date

\_\_\_\_\_  
District/SELPA Administrator's Signature date