School Based Mental Health Referral

Date created by referent: _____

Student name: _____
First Last

Student address: _____

DOB: _____ Grade: _____ Gender: _____

Student phone: _____

When was referral discussed with student? _____ Response? _____

_____

Parent / Guardian name: _____ Phone number: _____

When was parent contacted regarding referral? _____ Response? _____

Race/ethnicity as identified by student: _____

Student's Primary Language: _____ Interpreter Needed?: Y/N

Parent's Primary Language: _____ Interpreter Needed?: Y/N

School: _____ School District: _____

Name of person making referral for Mental Health: _____

Relationship to student: _____

Is the client on an IEP? ☐ 504 plan? ☐ Disciplinary action? ☐

Substance abuse? ☐ Threat of Harm to self or others? ☐

Insurance information from Health Clinic or Student Registration form:

Name of Insurance: _____ Policy ID Number: _____

Primary Care Provider: _____ Primary Care Phone: _____

Describe the concern or reason for the referral (please be informative): _____

Other Professional Involvement:

Developmental Disabilities ☐ Child Welfare ☐ Juvenile Justice ☐

School Police ☐ Mental Health Provider ☐ SUN ☐

If any boxes checked, please provide name and phone number of contact person / case mgr:

Name: _____ Phone: _____

Date received by MHC: _____ MHC Name: _____