REFERRAL FOR SCHOOL-BASED MENTAL HEALTH (SBMH) SERVICES (04/02/2014)

School:______________________________ School Unique ID #:____________

School System:______________________________ System Unique ID #:____________

MH Provider:______________________________ MH Provider 3-Digit ID #:________

MH Therapist:______________________________ MH Therapist 4-Digit Worker ID #:________

Student Being Referred:______________________________ SSID #:______________

DOB:________ Age:____ Race:___ Sex:___ MH Record # (If Accepted into Services):______________

Teacher:______________________________ Grade:____ Regular Ed:_____ Special Ed:_____

Exceptionality (or N/A):______________________________

Date of Referral:____________ School Counselor Making Referral:______________________________

Insurance Info: Medicaid:______ AllKids:______ Other:__________________ None:______

Parent or Legal Guardian (circle which) Name:______________________________

Student's Home Address:______________________________

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Student lives with Parent/Guardian? (Circle): YES NO If not, explain:______________________________

Home Phone #:______________ Cell Phone #:______________ Work/Other Phone#:______________

Parent/Guardian notified of referral by School Counselor and agrees to screening for MH services? (Circle): YES NO

CONCERNING BEHAVIORS (CHECK ALL THAT APPLY)

____ Reports Abuse	____ Victim of Crime/Violence	____ Suicidal Behaviors/Threats
____ Recent Traumatic Event	____ Peer/Social Problems	____ Parent/Child Conflict
____ Unusual Changes in Mood	____ Eating Problems	____ Substance Use Problems
____ Withdrawn/Depression	____ Recent Loss or Separation	____ Excessive Crying/Sadness
____ Angry/Agitated	____ Violent Outbursts	____ Fighting/Destroying Property
____ Resistant to Authority	____ Legal/Court Problems	____ High Risk Behaviors
____ Sexual Misconduct	____ Bullying (Perp./Victim)	____ Reports Sleep Problems
____ Inattentive/Hyperactive	____ Changes in Grades	____ Reports Fears/Phobias
____ Anxiety/Excessive Worry	____ Strange/Bizarre Behaviors	____ Reports Hallucinations

Notes:______________________________

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Referral Accepted:____ Referral Denied:____ Reason for Denial:______________________________

Date Accepted/Denied:____________ Date Services Started:____________ Date Services Ended:____________