REFERRAL FOR SCHOOL-BASED MENTAL HEALTH (SBMH) SERVICES

School: _____ School Unique ID #: _____

School System: _____ System Unique ID #: 002

MH Provider: _____ MH Provider 3-Digit ID #: _005__

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 NA): _____

Date of Referral: _____ School Counselor Making Referral: _____

Insurance Info: Medicaid: _____ AllKids: _____ Other: _____ None: _____

Parent or Legal Guardian (circle which) Name: _____

Student's Home Address: _____

_____

Student lives with Parent/Guardian (Circle): YES NO If No, 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

FSIQ: _____ Individual/Family Counseling: _____ Assessment for Day Treatment: _____

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____ Withdrawn/Depression	____ Recent Loss or Separation	____ Excessive Crying/Sadness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

Notes/Strategies Used by School in Attempt to Modify Behavior:_____

_____

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

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