LEE CARLSON CENTER™
For Mental Health & Well-Being

CONFIDENTIAL SCHOOL-LINKED MENTAL HEALTH REFERRAL FORM

Email completed referral form to: SLMHreferral@LeeCarlsonCenter.org

Today's Date: __________________ Date you contacted parent/guardian about the referral: ________________

Referrent Information

Name of person making referral: _____________________________________ Phone #: ____________________

☐ I have confirmed with referring family that the student is not currently receiving therapeutic services.

Student Information

Student First & Last Name: ____ Grade: _________

School: ____ DOB: _____________________ Sex: ☐ Male ☐ Female

Is student currently receiving Special Education services and has an IEP?

☐ Has IEP, includes mental health services ☐ Has IEP, does not includes mental health services ☐ No IEP

Street Address: ____

City/State/Zip: __________________________ ____

Parent Information

Parent/Guardian(s) Name(s): ____

☐ I have verified that this person has physical and legal custody of child.

Home phone: ____________________ Cell Phone: ____________________ Work Phone: ___________________

Parent email(s): ____

Preferred method of contact: ☐ Home Phone ☐ Cell phone ☐ Work phone

Contact notes if any (ex: call parents after work hours, etc): ____

Does client need interpreter? ☐ No ☐ Yes if yes, what language: ______________________________________

Reason(s) for referral:

☐ Sadness
☐ Worries
☐ Aggression
☐ Family Concerns
☐ Sexual Orientation
☐ Grief
☐ Social Skills
☐ Bullying
☐ Fighting
☐ Chem Dep
☐ Peer Relationships
☐ Impulsive
☐ Self-Image
☐ Nervous/Anxious
☐ School Avoidance
☐ Defiant/Oppositional
☐ Hyperactive
☐ Self- Harm
☐ Hyperactivity/Inattention
☐ Eating Disorder

☐ Other: ____

Clarify referral reason if needed:

CONFIDENTIAL