CONFIDENTIAL SCHOOL-LINKED MENTAL HEALTH REFERRAL FORM

Email completed referral form to your school-based therapist and the district lead

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

Last Name: __________________________________ First Name: __________________________________

Middle Name: ___________________________ DOB: _________________________ Sex: ☐ Male ☐ Female

Preferred name and Pronoun: ____

Physical Address: ____

City/State/zip: ____ County: _______________________

Grade: ________ School: ____

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

Is there a 504 plan in place? ☐ No ☐Yes

Parent Information

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

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

Marital status of parents (Married, Divorced, Seperated, Other): ____________________________________

Home phone: ___________________ Cell Phone: ___________________ Work Phone: __________________

Parent/Guardian email(s): ____

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

Preferred time of day to contact: ____

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

Reason(s) for referral:

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

☐ Other: ____

Clarify referral reason if needed:

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