Behavioral Health Referral for School Based Health Center

School: _____

Referring Person/Role: _____ **Date:**_____

Referring Person Agency: _____ **Phone:** _____

CLIENT INFORMATION

Client Name: _____ DOB: _____ Grade: _____

Client Address: _____

Mother/Guardian Name: _____ Phone Number: _____

Father/Guardian Name: _____ Phone Number: _____

Parent/Guardian Relationship to Client: _____

Client Ethnicity: _____ Client Gender: _____

Client speaks/understands: □ English □ Spanish Only □English and Spanish □ Other_____

Parent/Guardian speaks/understands: □ English □ Spanish Only □English & Spanish □Other_____

Primary Insurance: _____ Policy/ID Number: _____

Secondary Insurance: _____ Policy/ID Number: _____

DCF involvement: □No □Yes: DCF Link#: _____ Legal Mandate: □No □ Yes: □Court □Probation □Family Relations

Reason for Referral:

_____

_____

_____

_____

_____

_____

Any prior mental health services at CS-HHC or elsewhere? □No □Yes, where and when? _____

_____

Is the client suicidal or homicidal? □ No □Yes, please specify : _____

Any hospitalizations? □No □Yes, please specify: _____

Any current medications? □No □Yes, please specify: _____

Any drug or alcohol abuse? □ No □Yes, please specify: _____

For Office Use Only:

Date Contacted Parent: _____ □Messsage Left □No voicemail

Date Contacted Parent: _____ □Messsage Left □No voicemail

Date Contacted Parent: _____ □Messsage Left □No voicemail

Intake Scheduled Date: _____ Services Declined Date: _____

Services Not Appropriate for SBHC (Explain): _____