School Behavioral Health Referral

Referring Party: ____Phone#_________________________

Email Address:____School:_________________________________

Date referred:_______________________________ Request for in school counseling: YES________ NO_______

Client Information:

<table>
<tr><td>Last Name:</td><td>First Name:</td><td colspan="2">Grade in School:</td></tr>
<tr><td colspan="2">Have you ever been seen here before?
Yes or No</td><td colspan="2">Client #: (For Office Use Only)</td></tr>
<tr><td>SS#:</td><td>DOB:</td><td colspan="2">Sex:
Male Female Transgender</td></tr>
<tr><td colspan="2">Mailing Address, City, State, Zip:</td><td colspan="2">Physical Address, City, State, Zip:</td></tr>
<tr><td colspan="2">Contact Preference:
____Home
____Cell Phone
____Email
____Text Message</td><td colspan="2">Contact Info:
Home Phone: ________________________________
Cell Phone: __________________________________
Email: ______________________________________
Text Message: ________________________________</td></tr>
<tr><td colspan="4">Emergency Contact Information:
Name: ____________________________________Relationship to Client:___________________________
Phone#:___________________________________</td></tr>
</table>

Parent/Guardian Information:

<table>
<tr><td>Last Name:</td><td>First Name:</td><td>Relationship to Client:</td></tr>
<tr><td>Sex:
Male Female Transgender</td><td>SS#:</td><td>DOB:</td></tr>
<tr><td>Home Phone:</td><td>Cell Phone:</td><td>Work Phone:</td></tr>
<tr><td colspan="3">Address, City, State, Zip:</td></tr>
</table>

Insurance/Payment Information:

Insurance Type:____

Special funds request or arrangements for payment:____

Living Arrangements:

With whom does child live with?	Relationship:	Does child want parental involvement? ________Yes _________No

Notifications:

Has parent been notified of this referral? ________Yes ________No ________Left message	Date Notified:
Does the student know about this referral? ________Yes ________No	Is student interested in case management, therapy or both?

Referral Background Information:

Identify the presenting problem or concerns that led to this referral:
Referring party's observations/insights that will aid in this referral and overall treatment:
Does the client have barriers to treatment? (Lack of parental involvement, no transportation, etc.)