NEW HANOVER COUNTY
PUBLIC HEALTH
2029 South 17th Street, Wilmington, NC 28401
P: (910) 798-6500 | F: (910) 772-7805 | NHCgov.com
Phillip E. Tarte, MHA, Director

REFERRAL FOR SCHOOL BASED MENTAL HEALTH SERVICES

Student Information

Name of Student: _____ **DOB:** _____

Gender: _____ **Race:** _____ **Country of Origin:** _____

Name of Parent/Guardian: _____ **DOB:** _____

Address: _____ **Contact Number(s):**_____

Name of Insurance and Number: _____

School Information

Current School: _____ **Grade:** _____

Teacher: _____ **Contact Number:** _____

Referral Information:

Reason for Referral (please be as specific as possible): _____

_____

_____

_____

Has the parent been informed of the services available?	**Yes**	**No**
Has the parent been informed that a referral is being made?	**Yes**	**No**
Has the parent agreed with utilizing the services?	**Yes**	**No**
Are there any school records you feel will be helpful to the therapist?	**Yes**	**No**
Do you want follow-up information from the therapist assigned?	**Yes**	**No**

Additional Comments: _____

_____

_____

Person Making Referral: _____

Contact Number: _____ **Date of Referral:** _____

****

For Therapist Use Only:

Follow-up Date: _____ **Outcome:** _____

Type of Follow-up: _____ **Phone;** _____ **Letter;** _____ **Face-to-face;** _____ **Other** _____

Follow-up Date: _____ **Outcome:** _____

Type of Follow-up: _____ **Phone;** _____ **Letter;** _____ **Face-to-face;** _____ **Other** _____

Admitted to Program? (circle) YES NO **Date Admitted:** _____