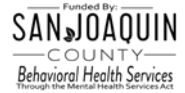




STUDENT INFORMATION FORM



Student Name:
Student Date of Birth:
Student Grade:
Address:
Phone Number:
Parent's Name:
Date Referral was received:
Date PHQ9 was administered:
PHQ9 Score:
Referral Date:
Referral Type:
Name of Organization & Program student is being referred to:
Date of most recent MH treatment: MONTH _____ YEAR _____
Number of months of untreated mental illness:
Number of years of untreated mental illness:

Name of Student:	Date of Referral:
Parent Name:	Parent Contact #:
Referral Submitted By:	

Please indicate why this referral is necessary below:

- | | | |
|---|--|---|
| <input type="checkbox"/> Suicidal or history of suicidality | <input type="checkbox"/> Attention-seeking/reckless behavior | <input type="checkbox"/> Academic concerns |
| <input type="checkbox"/> Recent hospitalization | <input type="checkbox"/> Social/emotional concerns | <input type="checkbox"/> Family/home concerns |
| <input type="checkbox"/> Behavioral concerns | <input type="checkbox"/> Isolation | <input type="checkbox"/> Bullying |

Please indicate specific areas of concern below:

- | | | |
|---|---|---|
| <input type="checkbox"/> Persistent sad mood (i.e. crying, withdrawn) | <input type="checkbox"/> Frequent somatic complaints unrelated to a medical condition (ex: headaches, etc.) | <input type="checkbox"/> Destruction of property |
| <input type="checkbox"/> Verbalizes feeling hopeless/empty/sad | <input type="checkbox"/> Parent's divorce/separation | <input type="checkbox"/> Persistent irritable mood |
| <input type="checkbox"/> Poor/deteriorated hygiene | <input type="checkbox"/> Withdrawing from friends and/or family | <input type="checkbox"/> Marked decrease in concentration |
| <input type="checkbox"/> Lack of enjoyment in majority of activities | <input type="checkbox"/> Abusing drugs and/or alcohol | <input type="checkbox"/> Sudden change in mood/behavior |
| <input type="checkbox"/> Sudden, unintended weight loss/gain | <input type="checkbox"/> Verbally/physically threatening/aggressive | <input type="checkbox"/> Life-threatening behaviors |
| <input type="checkbox"/> Persistently falling asleep in class | <input type="checkbox"/> Victim of bullying/bullying others | <input type="checkbox"/> Excessive absenteeism/tardiness |
| <input type="checkbox"/> Reports feeling worthless | <input type="checkbox"/> History of trauma (ex: physical, emotional, sexual abuse, violence, neglect, etc.) | <input type="checkbox"/> Slipping grades/not performing at grade level |
| <input type="checkbox"/> Talking/writing about death or suicide | <input type="checkbox"/> Overtly sexual behaviors | <input type="checkbox"/> New transitions (ex: move, lifestyle change, etc.) |
| <input type="checkbox"/> Self-harm behaviors (ex: cutting) | <input type="checkbox"/> Excessive worry and/or guilt | <input type="checkbox"/> Lacks coping/problem-solving skills |
| <input type="checkbox"/> Break up with girl/boyfriend | <input type="checkbox"/> Frequent angry outbursts | <input type="checkbox"/> Lack of support system |
| <input type="checkbox"/> Out of home placement | | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Homeless | | |
| <input type="checkbox"/> Death of a family/friend | | |

Brief description of problem:

Please include any additional information about concerns, including relevant information about family, etc. in the box below:

CAPC USE ONLY

CAST ___ BFFD ___ PHQ-9 ___ DEMOGRAPHIC ___ ROI