familylinks
Strong. For life.

Mental Health Partnership Referral and Permission Slip

All information below must be completed in order to process this referral.

Student Name:		
School:		**Grade:**
Student Address:		
DOB:	**SS#** (for billing/insurance purposes only)**:**	**Race/Ethnicity:**
Phone (list all)**:**		
Email:		
Name of Policy Holder:		
Type of Insurance:		
Policy #:	**Group #:**	
Parent/Guardian Name(s) and Relationship:		

Concerns (to be completed by school and parent/guardian):
Strengths (student and family)**:**

****All referral forms should be faxed directly to Familylinks Centralized Intake Department: 412-924-0259 OR emailed to centralized_intake@familylinks.org****