Pathways Behavioral Health Services
School Based Liaison – At Risk Youth Services

CONSULTATION REQUEST FORM (CRF)

Date of Request:_____

Requesting Teacher:_____

Student's Name:_____Grade:_____

School (check one):
- ☐ Crockett Middle School
- ☐ Crockett High School
- ☐ Crockett Alternative School

Student currently identified as:

- ☐ Yes ☐ No Special Education
- ☐ Yes ☐ No Emotionally Disturbed (ED)
- ☐ Yes ☐ No Substance Use/Abuse Disorder (SUAD)?

Reason for Request: (Check all that apply)

- ☐ Poor Academic Performance
- ☐ Disruptive Behavior in classroom
- ☐ Emotional Disturbance
- ☐ Increase in Environmental Stressors
- ☐ Discharge from psychiatric hospital or residential treatment facility

Planning Period/Best Time to Discuss: _____

_____
REQUESTING TEACHER SIGNATURE

Please do not write below this line

Date of consultation _____

Identified Need _____

Plan of Action _____

☐ Additional Scales and/or rating measures given to teacher?

☐ Parental permission form discussed and given to teacher?

_____
LIAISON SIGNATURE

Important Numbers:

Youth Villages Crisis (18 and under) – 1-866-791-9227

Pathways Crisis (18 and older) – 1-800-372-0693

Pathways Behavioral Health- 1-800-587-3854 or 731-541-8200

Child Abuse Hotline- 1-877-237-0004

W.R.A.P Crockett County- 1-800-273-8712 or 1-800-787-3224 (TTY)

Quinco Mental Health- 731-664-2083

kidcentral tn
KIDCENTRALTN.COM

YOUTHrecovery
PATHWAYS BEHAVIORAL HEALTH SERVICES
An affiliate of West Tennessee Healthcare

PARENTAL PERMISSION FOR SCHOOL MENTAL HEALTH SERVICES

2017-2018

Dear Parent/Guardian,

The purpose of this document is to request your permission to serve your child through the School Based Mental Health Liaison Program. The services are free and provided during the school day. The objective of services is to identify areas of need academically, emotionally, socially, and behaviorally. Your participation in the process is welcome and invaluable to your child. Please sign below in order for your child to receive services during the 2017- 2018 school year. The services are provided by a mental health professional from Pathways Behavioral Health Services and may include assessments, individual counseling, group counseling, and/ or classroom observations. Furthermore, the results and recommendations will be shared with your child's teachers and school administration as needed. A release of information for the school is required this year and it is on the back of this form. Lastly, your consent may be withdrawn at any time during the 2017-2018 school year.

Christie Polk, LCSW

Christie.Polk@wth.org

As the Parent/Legal Guardian of _____, I give my permission for my child to receive services during the 2017-2018 school year.

Parent/Legal Guardian

Signature: _____ Date:_____

If you would like to have a conference with the counselor either by phone or in person, please provide a phone number and best available times.

PATIENT NAME:	Birth Date:	SS No. (optional)
	Other Names Known By:	

INFORMATION BEING RELEASED BY: PATHWAYS BEHAVIORAL HEALTH SERVICES

Release Records To: Crockett Schools	Address:	City:	
	Telephone #:	State:	Zip:

e-Mail address: PLEASE PRINT:

Dates of Treatment:

Place of Treatment: _____Inpatient _____Outpatient _____Other (specify):

Purpose of Disclosure: _____ Continuing Care _____ Insurance _____Family Involvement
_____At the Request of the Individual _____ Other, Please Explain:
PATIENT PORTAL ACCESS_____

Choose From the Following (please initial beside documents):

____Multi-disciplinary Assessment
____Treatment Plan
____Discharge Summary
____Medical Progress Notes / Orders
____Clinical Progress Notes
____Lab (**may include AIDS/HIV information**)
____Medical Assessment
____Nursing Notes
____Letter
____Entire Chart
____Verbal Communication
____Completion of Submitted Form
____CRG/TPG
____Other (specify):

I understand that::

1. I may revoke this authorization in writing at any time, but if I do so, it will not have any effect on any actions taken by the facility releasing the information (hereafter referred to as "the facility") prior to the facility's receiving the revocation. Further details regarding the manner in which this authorization may be revoked may be found in the facility's Notice of Privacy Practices.
2. This authorization allows the facility to release the above-indicated documents in my medical record, including those copies from other health care facilities and providers as requested. The released information may no longer be protected by federal privacy regulations and may be re-disclosed.
3. Any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by Title 42 CFR, and if there is any such information, I hereby authorize the release of information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.
4. The facility is hereby released from any liability and the undersigned will hold the facility harmless for complying with this authorization.
5. The facility will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization, except for research related purposes and as otherwise permitted under applicable law.
6. The authorization will expire in 6 months unless I provide an alternate expiration date or event.

I have read and understood this authorization. I hereby authorize the release, use, and disclosure of the above-requested protected health information.

_____
Signature of Patient

_____
Date

Med Red # _____

_____
Signature of Patient's Authorized Representative

___Mother ___Father ___Legal Guardian ____other

if other, please specify_____

Witness_____

PATHWAYS BEHAVIORIAL HEALTH SERVICES
CORPORATE OFFICE
238 SUMMAR DRIVE
JACKSON, TN 38301
Corporate fax number 731-541-8327
MEDICAL RECORDS FAX 731-541-8265

□CORP. OFFICE	□HAYWOOD COUNTY	□OBION COUNTY	□DYER COUNTY	□EAP	□HENDERSON COUNTY	□GIBSON COUNTY
238 Summar Drive Jackson, TN 38301 Ph: 731-541-8200 800-587-3854	1120 Tammbell St. Brownsville, TN 38012 Ph: 731-772-4685 Fax: 731-772-3072	PO Box 1022 Union City, TN 38281 Ph: 731-885-9333 Fax: 731-885-5860	2035 St. John Dyersburg, TN 38024 Ph: 731-285-1393 Fax: 731-286-1423	33 Director's Row, Ste A Jackson, TN 38305 Ph: 731-541-7605 Fax: 731-661-6277	9550 Hwy 412 West, Suite B Lexington, TN 38351 Ph: 731-968-8197 Fax: 731-967-1749	4039 S. Highland St Milan, TN 38358 Ph: 731-723-1327 Fax: 731-723-1339

CHECK APPROPRIATE ADDRESS