

# Referral for Mental Health Services

(Every section must be complete to process referral)

Today's Date: \_\_\_\_\_ Submitted By: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Birthdate (mm/dd/yy): \_\_\_\_\_

Grade: \_\_\_\_\_

Home Address (including zip code): \_\_\_\_\_

Guardian's Name (first and last): \_\_\_\_\_

Guardian's Phone Number: \_\_\_\_\_

Alternative number (if applicable): \_\_\_\_\_

Social worker name and phone number (if foster youth): \_\_\_\_\_

Preferred language: Guardian: \_\_\_\_\_ Student: \_\_\_\_\_

Is guardian aware of referral: \_\_\_\_\_

Teacher's name: \_\_\_\_\_

Student's Room # each period: 0 period \_\_\_\_\_ 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_ 4<sup>th</sup> \_\_\_\_\_ 5<sup>th</sup> \_\_\_\_\_ 6<sup>th</sup> \_\_\_\_\_

Does the student have an IEP? If so, please discuss referral with the school psychologist prior to submitting referral to ensure this is an appropriate service.

Referral due to IEP: YES NO

Reason for Referral:

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Please complete entire form and provide to school clinician. Including CMC consent form signed by guardian will allow services to begin without the potential delay of obtaining consent. Thank you!