GAP Team Referral Form

Child's Information		
Name:	Gender	Date of Birth
Address:		
School Name:	Grade:	
Does Student Currently Receive Mental Health Services?	If YES, Agency/Provider:	
Social Security Number:	Have the Parent/Guardians been contacted prior to submission of this referral? Yes No	

Name:	Relationship to Student:
Telephone:	

Parent/Guardian Information

Home: Preferred?	Cell: Preferred?	Work: Preferred?

Primary Insurance Information (If Known)

Insurance Carrier:

Phone:	Email:

Brief Description of Presenting Problem