



ALL SECTIONS MUST BE COMPLETED FOR REFERRAL TO BE PROCESSED

**WE ARE UNABLE TO PROCESS INCOMPLETE REFERRALS**

**School District & Building Name :** \_\_\_\_\_ **Date of Referral:** \_\_\_\_\_

Student Legal Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Age: \_\_\_\_\_ Race: \_\_\_\_\_ Gender: \_\_\_\_\_

What are the student's preferred pronouns?(him/his, she/hers, them/they) \_\_\_\_\_

Student Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Student Phone (over 14 years old) \_\_\_\_\_ Student Email (over 14 years old) \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Parent/Guardian Address: \_\_\_\_\_

Parent/Guardian Phone Number: \_\_\_\_\_ Parent/Guardian Email: \_\_\_\_\_

Preferred method of contact: Home phone    Cell phone    Work phone    Email    Text

Custody Arrangement: Primary \_\_\_\_\_ Shared \_\_\_\_\_ Other \_\_\_\_\_

**\*If shared custody please complete Additional Parent/Guardian section below:**

Parent/Guardian: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Parent/Guardian Address: \_\_\_\_\_

Parent/Guardian Phone Number: \_\_\_\_\_ Parent/Guardian Email: \_\_\_\_\_

Has CYF ever been involved?: Yes \_\_\_\_\_ No \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Contact phone number: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Mental Health/Behavioral Health Insurance Information:**

Insurance: \_\_\_\_\_

STATE Medicaid/MA ID (10 Digits): \_\_\_\_\_

Private Insurance Carrier Name: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

\*Does the Insurance Provider Cover Telehealth? YES \_\_\_ NO \_\_\_

**\*IF UNKNOWN, PLEASE INQUIRE WITH YOUR INSURANCE**

Policy Holder of Private Insurance: \_\_\_\_\_

Policy Holder DOB: \_\_\_\_\_ Policy Holder Employer: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

**Reason For Referral:**

\_\_\_ Physical Aggression \_\_\_ Verbal Aggression \_\_\_ Anxiety \_\_\_ Mood \_\_\_ Depression

\_\_\_ Substance Use \_\_\_ Anger \_\_\_ Behaviors \_\_\_ Autism \_\_\_ Hyperactivity

\_\_\_ Impulsive \_\_\_ Trauma \_\_\_ Lack of attention \_\_\_ Poor Choices

Risk of harming self or others \_\_\_ Other: \_\_\_\_\_

Are there concerns that the student is abusing alcohol or substances?: Yes \_\_\_ No \_\_\_

Are these behaviors occurring in the home?: Yes \_\_\_ No \_\_\_

Are these behaviors occurring at school?: Yes \_\_\_ No \_\_\_

Please check what service(s) you are interested in: Group Therapy \_\_\_ Individual Therapy \_\_\_

Are you currently receiving another type of therapeutic service?: Yes \_\_\_ No \_\_\_

Current therapist/psychiatrist: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Doctor Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Address: \_\_\_\_\_

**\*My signature certifies that I have medical rights to request this child receive services.**

Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

**For Guardian/Parent-- Please return this form to your School Contact**

Email referral form to: [sbmhreferrals@gladerun.org](mailto:sbmhreferrals@gladerun.org)  
For Questions, please contact Glade Run Building Supervisor