Emergence Health Network

Teacher/Administration Screening Form
EHN School-Based Services
(To be completed by teacher, coach, or administrative staff)

Date of Referral:	

REFERRING PERSON INFO

Name of Referring Staff:	
Title:	
Phone Number:	
Email Address:	

STUDENT INFO

Student Name:		**Student ID Number:**	
Student DOB:		**Student Grade:**	
Student Preferred Language:			
Is the student agreeable to mental health services? YES NO			

Reason for Referral:
Please describe reason for referral (information and/or concerns):

___ Changes in mood at home or at school
___ Feeling very worried, nervous, or anxious
___ Experienced/experiencing a loss or death
___ Experienced/experiencing abuse or trauma
___ Sexual/gender identity issues
___ Aggressive or violent at home or school
___ Trouble adjusting to a change at home or school
___ Eating disturbances
___ Substance misuse
___ Suicidal Ideations
___ Self-harming behaviors
___ Other: _____

Notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Thank you! Should you have any questions, please reach out to the school counselor.
Please send completed referral to school counselor.