



HAMPTON COUNTY SCHOOL DISTRICT

Mental Health Referral

Email completed form to jwilliams@hcsdsc.org

Date: _____ Referral Made by: _____

Student Name: _____ DOB: _____ Grade: _____

School: _____ Teacher: _____

Parent: _____

Physical Address: _____

Mailing Address: _____

Phone: Home _____ Work _____ Cell _____

Reason for Referral: _____

Symptoms

___ Academic Performance

___ Depression

___ Other (Note below)

___ Classroom Conduct

___ Anxiety

___ Behavior

___ Grief/Loss

___ Trauma

___ Family/Community Related Concern

___ Suicidal Thoughts/Ideations

___ Drug and Alcohol Use

___ Homicidal Thoughts/Ideations

___ Health and Wellness

___ Self-Harm

___ Isolation/Withdrawn

Additional Comments: _____

FOR STAFF USE ONLY

Referral Date Received: _____

Recommendations: _____

Contact Date Attempts: _____

Appointment Date: _____