Phone: 716-831-1977 (ext. #1678) | Fax: 716-831-1985 | SAFERReferrals@horizon-health.org

HORIZON HEALTH SERVICES SAFER PROGRAM
REFERRAL FORM

Date of Referral: ____________

Name: ________________________ DOB: ________

Grade: ______________ School: _______________________

Address: _______________________

City: __________________________ State: _____ ZIP: _________

Gender: ____________________

Race: ____________________

Ethnicity: ____________________

Personal Phone Number: ___________________

Parent/s permission for in-school/community-based counseling: ____ Yes _____ No

Parent/Guardian #1: _______________________ DOB: _______

Phone: ________________ Email: _________________________

Relationship to the child: _______________________

Parent/Guardian#2: _______________________ DOB: _______

Phone: ________________ Email: __________________________

Relationship to the child: _______________________

Primary Insurance Name: _____________________________

Insurance ID#: ________________________________

Medicaid coverage: ____Yes _____ No If yes, Medicaid # _______________

Primary Care Physician: ___________________________________

Is the student currently taking any medications? _______________

If yes, what medications? __________________________________

Reason(s) for referral:

Other ________________

Horizon HEALTH SERVICES