Referral for Mental Health Services

Who is submitting this referral? ☐ Parent ☐ Principal ☐ School Counselor ☐ Student

Name of individual making referral: _____ Date of referral: _____

Student Name: _____ Birthdate: _____

Parent/Legal Guardian Name: _____ Telephone Number: _____

Why would you like to refer this student for therapy? Please describe the student's behaviors, feelings, circumstances, and incidents which have led to you feeling that a referral would be beneficial:

_____

_____

_____

Which concerns/needs have been observed by you and/or other staff members? (please circle)

Anxiety Depression Sleeping in Class Grief/Loss Anger Verbally Threatening

Physically Threatening Sexual Remarks/Behavior Substance Abuse Hygiene Attendance

Drastic/Sudden Changes (grades, behavior, attendance, attitude, etc.) Family Concerns

Self-Harm Suicidal Thoughts/Remarks Other: _____

Is the student currently meeting with a mental health provider in the community? ☐ Yes ☐ No

If "yes," who is the student meeting with? Name_____ Telephone Number_____

If "yes," is the parent/guardian willing to sign a Release of Information in order for the MH Specialist to coordinate with the community provider? ☐ Yes ☐ No

Have you already spoken with the student's parent/guardian about your concerns? ☐ Yes ☐ No

Have you informed the student's parent/guardian about the services offered by your school's Mental Health Specialist? ☐ Yes ☐ No

*** Please note: Elementary MH Specialists may need to gather additional information from the individual completing this form, and may ask the student's teacher to fill out a "Teacher Reflection Form" as part of this process.