Referral for School-Based Programs

Referral Information

Referral Source:	**Date of Referral:** / /
Phone # of Referral Source: - x	**Relationship to Student:**

Student Information

Student Name: | **School Attending:**
Grade: | **Student ID#:** | **Birthdate:** / / | **SS#:** - -
Have an IEP or SAT plan? ☐Y ☐N ☐ Unknown | **Monitoring Teacher:**
Home Phone #: - | **Caregiver:** | **CG Work/Cell #:** -
Student Work/Cell #: - | **Address:**
Student has the following type(s) of medical coverage:
☐ Insurance ☐ Medicaid ☐ CHIP ☐ Charity Care ☐ None ☐Unknown

Reason for Referral:

☐suicide risk – *notify staff NOW*	☐depression	☐grief
☐dropout risk	☐gang involvement	☐pregnancy support
☐eating problems	☐physical/sexual abuse	☐neglect
☐reactions to chronic illness	☐self esteem	☐family/relationship problems
☐anxiety/phobia/shyness	☐legal problems	☐aggression/violence
☐new student/freshman	☐drug/alcohol abuse	☐overactive/restlessness
☐poor grades	☐frequent absences/tardies	☐other

Has the student/family asked for information about services or for help? ☐Y ☐N

Other specific concerns or information about the cause of a problem or other important factors related to the situation (use the back if necessary).

Has the student ever received or is the student currently receiving mental health services?
☐ No ☐ Unknown ☐ Yes – Please specify which agency, if known:

To be completed by Prestera employees for internal referrals only:

Case Number:	**Last assess:** / /	**Last MISP:** / /
Medications:	**Doctor:**	

To be completed by School Based Clinician Only:

Follow-Up Confirmation *(First attempt must occur within 7 days)*

Date	Occurrence	Initials
/ /		
/ /		
/ /		
/ /		
/ /		
/ /		
/ /		
/ /		
/ /		
/ /		

Please complete this form electronically and/or print it. Submit to the school's Health Center or the School-Based Staff. If off-site, email to Wayne.Bennett@prestera.org or Meggan.Reed@prestera.org , or fax to (304)399-1202