SCHOOL BASED BEHAVIORAL HEALTH COUNSELING SERVICES INITIAL REFERRAL FORM

STUDENT INFORMATION

STUDENT'S NAME:		
REFERRAL DATE:	DATE OF BIRTH:	PHONE:
CURRENT ADDRESS:		
CITY:	STATE:	ZIP CODE:
LEGAL GUARDIAN: PARENT GRANDPARENT DCFS OTHER (specify)		

STUDENT DEMOGRAPHIC INFORMATION

SEX: MALE FEMALE OTHER	AGE:	CURRENT GRADE:
RACE:	ETHNICITY:	IEP/504: YES NP

EMERGENCY CONTACT

NAME OF EMERGENCY CONTACT:	
PHONE:	RELATIONSHIP:

PARENT INFORMATION

PARENT #1 NAME:	PARENT #2 NAME:
ADDRESS:	ADDRESS:
CITY:	CITY:
STATE: ZIP CODE	STATE: ZIP CODE:
PLACE OF EMPLOYMENT:	PLACE OF EMPLOYMENT:

SIBLINGS

NAME: AGE:	NAME: AGE:
NAME: AGE:	NAME: AGE:

REASON FOR REFERRAL (INCLUDING HISTORY OF SUICIDALITY/SELF-HARM &FAMILY DYNAMICS INFORMATION

VERBAL CONSENT TO SERVICES

NAME OF PARENT/GUARDIAN CONTACTED:	DATE OF CONTACT AND BY WHOM:
DOES PARENT/GUARDIAN CONSENT TO SERVICES:	DOES PARENT UNDERSTAND THIS A BILLED SERVICE: YES NO