York/Adams Mental Health-Intellectual & Developmental Disabilities

YORK/ADAMS MH-IDD
SCHOOL BASED
CASE MANAGEMENT

REFERRAL FORM

Student Name: _____ DOB: _____ Sex: _____

Address: _____

School District/School Building: _____

Name of Parent/Guardian: _____

Phone #: _____ E-mail Address: _____

*Diagnosis (if known): _____

**If you are a provider/treating physician, please include supporting documentation of this diagnosis, if possible.*

Presenting Concerns: _____

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REFERRAL SOURCE

Name: _____ Relationship: _____

Phone #: _____ E-mail Address: _____

Referral Date: _____ Is student/family aware of referral? ☐ Yes ☐ No

OFFICE USE ONLY

Date Received by MH-IDD: SSN: _____

_____ MA/Insurance: _____

Please email completed referral form to Del Franz, MH-IDD Children's Supervisor of School Based Liaisons at DRFranz@YorkCountyPA.gov. For more information contact Del at 717-818-9444.