**Referral for Co-Located Mental Health Assessments and Services**

*Submit referral to your school Student Services Support team for review to ensure appropriateness and contact with parent/guardian prior to providing copy to the School-Based Therapist.*

**Referral Date:** **School:**

**Student Name:** **Date of Birth:** **Race:**

**Grade:****\*EC: Yes**  **No**  **Student’s Phone #:**

**Student’s Address:**

**Referral Source:** **Relationship to Student:**

**If the student speaks Spanish, how important is it that they receive services in Spanish?**

not importantsomewhat important very important essential

**Reason for Referral:**

**Difficulty making transition:** new student  new city  new to class

**Interfering behaviors:** aggressive  shy  overactive other

**Achievement Problems:**  poor grades  poor skills  low motivation  poor attendance

**Major psychological/mental health concerns**:

drug/alcohol abuse  depression  suicide

grief  eating problems  anxiety/phobia

self-esteem  neglect  physical/sexual abuse

family/relationship problems  reactions to chronic illness  dropout prevention

gang involvement  pregnancy support  legal problems

other

**Other specific concerns:**

**Current school functioning:**

**Suspension: Out of School**  seldom  1x/month 2-3x/month 4+/month

**Suspension: In School**  seldom  1x/month 2-3x/month 4+/month

**Absent from school:**  seldom  1x/month 2-3x/month 4+/month

**Overall academic performance:** poor grades  poor study skills  low motivation

**Has the student/family asked for:** Information about service Y N

Requesting appointment to initiate help Y N

School contacted parent/student to offer help Y N

**\*Follow-Up/Confirmation by DPS: Complete and check the following:**

Date: \_\_/\_\_\_/\_\_\_ **Parent/Guardian Response:** □ Declined □ Accepted/consent form signed

**Follow-Up/Confirmation by Provider: Complete and check the following:**

Date: \_\_/\_\_\_/\_\_\_ **First Attempt:** □ declined □ accepted □ scheduled assessment

Date: \_\_/\_\_\_/\_\_\_ **Second Attempt:** □ declined □ accepted □ scheduled assessment □ no show

Date: \_\_/\_\_\_/\_\_\_ **Third Attempt:** □ declined □ accepted □ scheduled assessment □ no show □ returned referral to school staff

**Comprehensive assessment/intake completed:** Date: \_\_/\_\_\_/\_\_\_

**\*If student has an IEP, please notify your EC Facilitator**

Co-Located Mental Health Assessments & Services

*Co-Located Mental Health is an insurance based program. However, students will not be denied access to mental health services because of their inability to pay. The mental health provider will work with your school’s Student Services Support team to ensure – with our approval – an appropriate plan your child.*

**NAME OF STUDENT:**

**SCHOOL:****GRADE:**

**PARENT/GUARDIAN EMAIL:****PHONE#:**

**NAME OF INSURANCE PROVIDER IF APPLICABLE:**

I, Parent/Guardian of       (student) understand that an agency representative will contact me to discuss the referral process that may include upon my agreement, a date and time for an intake appointment, consisting of a comprehensive clinical assessment/screening.

I, Parent/Guardian:       therefore grant permission for the assigned Co-Located Mental Health agency to utilize the attached information and Durham Public School release form as part of the referral process to determine appropriateness of mental health services for my child.

**Parent/Guardian Print Name:**

**Parent/Guardian Signature:****Date:**