Chart #: ______

Appt. Date/Time: _______________

School Linked Mental Health Referral Form

Child Information

Childs name: ____________________________ Sex: ________ Date of Birth: ______________ Race: ____________

Address: ____ Phone #: _______________________

School Attending: ____ Grade/Teacher: __________________________

Special Education: Yes/No If yes, how does student qualify? SLD EBD DCD ASD Other Sped Teacher: ________

* Have parents/guardians been made aware of services? Yes/No *Are they expecting a call for more information? Yes/No Who should be contacted: Guardian Name: _________________________ Phone #: ______________________

Reason for Referral:

____

____

____

Family Information

Father's Name: ___________________________________ Date of Birth: ________________

Address: ____ Phone #: ________________________

Mother's Name: _________________________________ Date of Birth: ________________

Address: ____ Phone #: ________________________

Foster parent/Guardian(s): Name: ______________________________________ Phone #: ________________________

Address: ____

Emergency Contact Person: Name: _____________________________________ Phone #: ________________________

Siblings Name:	Age:	Gender:	Resides with:
_______________________________________	____________	M F	____________________________________
_______________________________________	____________	M F	____________________________________
_______________________________________	____________	M F	____________________________________

Current services and/or past services provided:

____

____

____________________________________ _____________

Name and Phone # of Individual Making the Referral **Date**

Insurance Information (Office Use Only)

Name of Primary Client: ____________________________ Date of Birth: ______________

Insurance Company: ____________________________________ PMI (if applicable): _______________________

Primary Client Policy ID#: _______________________________ Group #: _______________________________

Name of Policy Holder: __________________________________ Date of Birth: __________________________

Address: ____

Policy Holder ID#: __________________________________ Group #: _____________________________________

Primary Client Lives With: ____

Lighthouse Child & Family Services: Phone #: 320-983-2335, Fax: 651-342-8029