School Referral

Date of Referral:

School Referral #:

Student's Information

Student's Name: Date of Birth:

Grade: School Counselor:

Student's Race: Hispanic (yes or no):

Religion:

Are you currently seeing a mental health provider (yes or no):

Primary Parent/Legal Guardian Contact Information

Parent/Legal Guardian's Name: Relationship:

Home Address: Zip Code:

Home Phone: Cell Phone:

Email:

Reason(s) for Referral:

Barrier(s) to care in the community (Please check all that apply):

☐ Limited financial resources

☐ Lack of reliable transportation

☐ Parent(s) work schedule

☐ Other (please explain):

School Referral

Follow-Up Plan (Please check all that apply):

☐ Student already has a current mental health provider in the community. Family is aware of school based therapy services if needed in future. Referral is closed.

☐ School Release of Information signed by student & legal guardian for release to Children's Wisconsin SBMH program and a copy is attached.

☐ Parent/Legal Guardian will call to schedule with therapist, if interested.

☐ Therapist may contact family to provide more information. **(Legal guardian signature required below.)**

AUTHORIZATION: I give the Children's Wisconsin School Based Mental Health Milwaukee program permission to contact me at the phone number(s) provided to facilitate this referral and to contact my child's referring provider to share information regarding this referral.

Parent/Guardian Signature:_____ Date:_____