Student Support Services/Exceptional Student Education

Mental Health Interventions Referral Form

Student Information

To be completed by referring school and sent to District Metal Health Team @ Manning Center

Student Name:_____ Date:_____

Student #:_____ School:_____ Grade:_____

Date of Birth:_____ Ethnicity:_____ Gender: ☐Female ☐Male

Parent/Guardian Name:_____ Parent notified of referral: ☐Yes ☐No

Parent/Guardian Role: ☐Parent ☐Step-parent ☐Legal Guardian ☐Grandparent ☐Foster Parent

☐Other: _____

Parent/Guardian Address: _____

Home Phone#:_____ Cell Phone#:_____ Other Phone #:_____

Parent/Guardian Email:_____ Primary Home Language:_____

Insurance (Include Type of Medicaid):_____

Presenting Problem (include SDQ score)

_____

_____

_____

Tier 2/3 Interventions Attempted:

_____

_____

_____

Agencies Currently/Previously Involved:

_____

_____

_____

Current School Functioning/Criteria Used for Referral (check all that apply):

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

Overall academic performance: ☐poor grades ☐poor skills ☐low motivation ☐change/class participation

Behavior: ☐5 or more discipline referrals/increase in discipline referrals ☐Bullying(perpetrator) ☐Withdrawn ☐Frequent visits to nurse

Trauma: ☐Abandonment ☐Domestic Violence ☐Loss of parent ☐abuse ☐Bullying(victim)

Agency Referred To:_____

Contract funding needed: ☐Yes ☐No ☐Unsure

Assistance Needed From Mental Health Specialist:

_____

Referred by:_____