NorthLakes
COMMUNITY CLINIC

ph. 888.834.4551 nlccwi.org

SCHOOL BASED BEHAVIORAL HEALTH REFERRAL FORM

Referral date: ______________________ School: ____

____ ____________________

Student Name: LAST FIRST **Date of Birth**

Students Preferred Pronoun: ❐ He ❐ She ❐ They

Student's Grade/Teacher: ____

Parent/Guardian name(s): ____

Contact Info.: Address ____

____

Phone Number ____

Do they support the referral? ❐ Yes ❐ No Date of conversation: ______________________

If yes, is the parent okay with the therapist initiating contact? ❐ Yes ❐ No

Is the child/student willing to participate in treatment/therapy? ❐ Yes ❐ No

Parent gave permission for therapist to access student's schedule to aid in scheduling the intake session?

❐ Yes (please attach) ❐ No

Referred by: ____

Organization/Agency: ____

Referral Contact Info (phone/email): ____

____

Reason for Referral: ____

____

This referral does not obligate the referring individual, school or agency for payment of any services. The clinic's staff will work with the student's family to locate a funding source.

PROVIDER'S NOTES

Insurance/Funding Source: ____

Date and location of intake: ____

Contact Notes: