ALL SECTIONS MUST BE COMPLETED FOR REFERRAL TO BE PROCESSED

WE ARE UNABLE TO PROCESS INCOMPLETE REFERRALS

Mental Health Partnership Referral Form – School:_____ Date of Referral: _____

Student Legal Name:_____ DOB:_____

SSN: _____ Grade: _____

Age: _____ Race: _____ Gender: _____

What are the student's preferred pronouns? _____

Student Address:_____

City_____ Zip Code_____

Parent/Guardian: _____ Relationship to Student:_____

Parent/Guardian Address: _____

Parent/Guardian Phone Number: _____Student Phone (over 14 years old)_____

Parent/Guardian Email: _____

Has CYF ever been involved?: Yes _____ No _____

Custody Arrangement: Primary _____ Shared _____ Other _____

Mental Health/Behavioral Health Insurance Information:

Insurance: _____

STATE Medicaid/MA ID (10 Digits): _____

Private Insurance Carrier Name: _____

ID #: _____ Group #: _____

Policy Holder of Private Insurance: _____

Policy Holder DOB: _____Policy Holder Employer: _____

Relationship to student: _____

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Serving Our Communities Since 1854

Reason For Referral:

____ Physical Aggression	____ Verbal Aggression
____ Mood	____ Depression
____ Anger	____ Behaviors
____ Hyperactivity	____ Impulsive
____ Lack of attention	____ Poor Choices
____ Risk of harming self or others	____ Other: _____

Are there concerns that the student is abusing alcohol or substances?: Yes_____ No_____

Are these behaviors occurring in the home?: Yes _____ No _____

Please check what service(s) you are interested in: Group Therapy ____ Individual Therapy ____

Are you currently receiving another type of therapeutic service?: Yes _____ No _____

Current therapist/psychiatrist: _____

Practice Name: _____

Doctor Name: _____

Phone Number: _____

Fax Number: _____

Address: _____

***My signature certifies that I have medical rights to request this child receives services.**

Guardian Signature _____ Date _____

Student Signature _____ Date _____

Email referral form to: sbmhreferrals@gladerun.org
For Questions, please contact Glade Run Building Supervisor