TRI·CITY Mental Health

Student Support Services Referral Form (Ages Pre-K to 25)

Please use this form to make a referral for Student Support Services. Please note that this referral is specifically for Student Support Services and is not a referral or request for Specialty Mental Health Services. Please submit referral to *spt@tricitymhs.org* or fax to *909-865-0730* - Attention: Student Support Services

Referring Party Information Referral Date: _____

Name of Referring Party: _____ Phone: _____

What is your relationship to the student that you are referring (select one)?

☐ I am a School Employee (school name): _____ Title: _____

☐ I am an Employee at another agency (agency name): _____ Title: _____

☐ I am the Parent or Legal Guardian of the Student ☐ I am the Student (age:12-25) ☐ I am - Other Relationship (enter rel. type): _____

Name of Student: _____ DOB: _____ Age: _____

Gender: _____ Race/ethnicity: _____

Street Address: _____ City: _____ Zip: _____

Is student homeless/unhoused? ☐No ☐Yes Student Phone Number (if 18+): _____

Preferred Language(s): _____ Is Student an English Language Learner? ☐No ☐Yes

Type of Insurance: ☐Medi-Cal ☐Private Insurance ☐Unknown/Other: _____ ☐None

Name of Current School: _____ Grade Level: _____

If the student is under 18, please also complete the following:

Parent/Guardian Name: _____ Relationship: _____

Preferred Language of Parent/Guardian: _____ Phone Number: _____

Has Parent/Guardian been notified about or made aware of this referral? ☐Yes ☐No

Can we contact Parent/Guardian? ☐Yes ☐No; If no please explain: _____

Reason for Referral

a. Please describe your reason for referring the student: _____

_____

b. Please answer the following questions:

To your knowledge, has the student ever…	Yes	No	Unsure
1. Been in a psychiatric hospital? – If ***Yes***, enter most recent discharge date: _____.	◯	◯	◯
2. Had thoughts, feelings, or behaviors of suicide?	◯	◯	◯
3. Had thoughts, feelings, or behaviors of self-harm?	◯	◯	◯
4. Had thoughts, feelings, or behaviors of harming others?	◯	◯	◯
5. Seen, heard, or believed things that others don't see/hear/observe?	◯	◯	◯
6. Been suspended or expelled?	◯	◯	◯
7. Been in foster care or a group home?	◯	◯	◯
8. Identified as a member of the LGBTQ+ community?	◯	◯	◯
9. Received Mental Health Treatment? – If ***Yes***, enter most recent date: _____.	◯	◯	◯

Signature of Referring Party - *I the undersigned request this referral to be initiated for the above listed student. I understand that incomplete information may result in a processing delay or closure of the referral.*

_____ _____ _____

Referring Party Signature **Printed Name** **Date**