northlakes COMMUNITY CLINIC

S.B. Behavioral Health
Ashland - Iron River - Washburn
Hayward - Minong
Turtle Lake - Balsam Lake

ph. (888) 834-4551 **northlakesclinic.org**

SCHOOL BASED BEHAVIORAL HEALTH REFERRAL FORM

Referral date: ______________________ Student's Grade: ____________ Student's Teacher: ___________

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

Students Preferred Pronoun: ❒ He ❒ She

Patient Contact Info.: Address ____

____

Phone Number ____

Parent/Guardian name(s): ____

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: ____

School or Organization/Agency: ____

Referral Contact Info (phone/email): ____

____

Reason for Referral: ____

____

____

<u>Return Form To:</u>

❒ NorthLakes Community Clinic- 214B
212 Maple Street S, PO Box 27
Turtle Lake, WI 54889
Fax) 715-986-2291

❒ NorthLakes Community Clinic
Downtown Clinic
300 Main Street W
Ashland, WI 54806
Fax) 715-685-1185

❒ NorthLakes Community Clinic
101 Thompson Road
Washburn, WI 54891
Fax) 715-373-5530

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: