northlakes COMMUNITY CLINIC

S.B. Behavioral Health

Ashland - Balsam Lake - Birchwood - Hayward
Iron River - Minong - Park Falls - Turtle Lake - Washburn

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