MENTAL HEALTH REFERRAL
TO MULTNOMAH COUNTY SCHOOL BASED HEALTH CENTERS
AND/OR THE SCHOOL BASED MENTAL HEALTH PROGRAM

1. IDENTIFYING INFORMATION: Referral Date: _____

Student Name: _____ Student ID#: _____

School _____ School District: _____

DOB: _____ Age: _____ Grade: _____ Student Ethnicity: _____ Gender: ☐ M ☐ F

Teacher/Counselor: _____ Student Cell Phone: _____

Parent/Guardian name(s): _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____ Address: _____

Does the student have a ***current*** IEP: ☐ Yes ☐ No Section 504 Plan: ☐ Yes ☐ No

Will the student and/or parent/guardian require the services of an interpreter? ☐ No ☐ Yes Language: _____

2. REFERRAL INFORMATION:

Referring Person: _____ Relationship to Student: _____

What is the concern? _____

_____

Are there concerns regarding the student's safety including high risk behaviors? ☐ Yes ☐ No Self Harm? ☐ Yes ☐ No

Harm Towards Others? ☐ Yes ☐ No Are there any concerns about the student's use of alcohol or drugs? ☐ Yes ☐ No

Is this referral tied to disciplinary action? ☐ Yes ☐ No If so, describe incident: _____

Referral made by School District Staff ☐ Yes ☐ No Referral made by SBHC staff: ☐ Yes ☐ No

If this is a school staff referral has an administrator been notified? Approved by _____

SERVICES REQUESTED: ___ For Information Only ___ Consultation ___ Crisis Intervention ___ Mental Health Assessment
___ Ongoing Mental Health Services Other: _____

3. PARENT CONTACT:

A. Has parent/guardian been contacted regarding referral? ☐ Yes ☐ No What is the best way to contact parents? _____

B. Name of parent/guardian contacted: _____

C. Date of contact: _____ Has student been contacted about this referral? ☐ Yes ☐ No Date of contact: _____

D. Is the parent/guardian aware of the student's presenting concerns? ☐ Yes ☐ No

4. REQUIRED HEALTH INFORMATION: (This information is critical.)

A. Does this student have Medicaid/Oregon Health Plan/Health Share of Oregon? ☐ Yes ☐ No OHP# _____

B. Does this student have Private Insurance? ☐ Yes ☐ No Name Of Insurance Co: _____

C. Has a referral been made to OHP? When? _____ Member ID# _____ Group# _____

D. Who is this student's Medical Provider? _____ Phone: _____

E. Is this student on any medication? ☐ Yes ☐ No ☐ Unknown Name of Medication: _____

_____

5. MEDICAL INFORMATION TO BE COMPLETED BY SBHC STAFF ONLY:

A. Date of Last Well Child Exam: _____ B. Current Medications: _____

C. Pertinent Medical History: _____

_____

D. Pertinent Medical Conditions: _____

_____

E. Pertinent Family History: _____

_____

G: Primary Care Provider: _____

6. OTHER PROFESSIONALS INVOLVED WITH STUDENT. For each yes, enter corresponding information below.

Department of Human Services ☐ Yes ☐ No Mental Health Provider ☐ Yes ☐ No SRO/Police ☐ Yes ☐ No

Developmental Disabilities ☐ Yes ☐ No Other: _____

KATHY RUBERG, MSW, LCSW

MHC: _____ Date Received: _____