DURHAM PUBLIC SCHOOLS

Referral for Co-Located Mental Health Assessments and Services

Submit referral to your school Student Services Support team for review to ensure appropriateness and contact with parent/guardian prior to providing copy to the School-Based Therapist.

Referral Date: **School:**

Student Name: **Date of Birth:** **Race:**

Grade: ***EC:** Yes ☐/ No ☐ **Student's Phone#:**

Student's Address:

Referral Source: **Relationship to Student**:

If the student speaks Spanish, how important is it that they receive services in Spanish?

☐ not important ☐ somewhat important ☐ very important ☐ essential

Reason for Referral:

Difficulty making transition:	☐ new student	☐ new city	☐ new to class	
Interfering behaviors:	☐ aggressive	☐ shy	☐ overactive	☐ other _____
Achievement problems:	☐ poor grades	☐ poor skills	☐ low motivation	☐ poor attendance

Major psychosocial/mental health concern:

☐ drug/alcohol abuse	☐ depression/suicide	☐ grief
☐ dropout prevention	☐ gang involvement	☐ pregnancy support
☐ eating problems	☐ physical/sexual abuse	☐ neglect
☐ reactions to chronic illness	☐ self esteem	☐ family/relationship problems
☐ anxiety/phobia	☐ legal problems	☐ other

Other specific concerns:

Current school functioning:

Suspension: Out of School	☐ seldom	☐ 1x/month	☐ 2-3x/month	☐ 4+/month
Suspension: In School	☐ seldom	☐ 1x/month	☐ 2-3x/month	☐ 4+/month
Absent from school:	☐ seldom	☐ 1x/month	☐ 2-3x/month	☐ 4+/month
Overall academic performance:	☐ poor grades	☐ poor study skills	☐ low motivation	

Has the student/family asked for:	Information about service	☐ Y ☐ N
	Requesting appointment to initiate help	☐ Y ☐ N
	School contacted parent/student to offer help	☐ Y ☐ N

***Follow-Up/Confirmation by DPS: Complete and check the following:**

Date: __/___/___ **Parent/Guardian Response:** □ Declined □ Accepted/consent form signed

Follow-Up/Confirmation by Provider: Complete and check the following:

Date: __/___/___ **First Attempt:** □ declined □ accepted □ scheduled assessment
Date: __/___/___ **Second Attempt:** □ declined □ accepted □ scheduled assessment □ no show
Date: __/___/___ **Third Attempt:** □ declined □ accepted □ scheduled assessment □ no show □ returned referral to school staff

Comprehensive assessment/intake completed: Date: __/___/___

Parent/Guardian Notification/Consent Form

Co-Located Mental Health Assessments & Services

Co-Located Mental Health is an insurance based program. However, students will not be denied access to mental health services because of their inability to pay. The mental health provider will work with your school's Student Services Support team to ensure – with our approval – an appropriate plan your child.

NAME OF STUDENT: _____

SCHOOL: _____ **GRADE**: _____

PARENT/GUARDIAN EMAIL: _____ **PHONE#:** _____

NAME OF INSURANCE PROVIDER IF APPLICABLE: _____

I, Parent/Guardian of _____ (student) understand that an agency representative will contact me to discuss the referral process that may include upon my agreement, a date and time for an intake appointment, consisting of a comprehensive clinical assessment/screening.

I, Parent/Guardian: _____ therefore grant permission for the assigned Co-Located Mental Health agency to utilize the attached information and Durham Public School release form as part of the referral process to determine appropriateness of mental health services for my child.

Parent/Guardian Print Name: _____

Parent/Guardian Signature: _____ **Date:**_____