Syracuse City School District

School Based Mental Health Partnership

Universal Referral Form

Child's Information		
Name: Last, First, Middle	Gender: ☐ Male ☐ Female	Date of Birth:
Address:		
Child's Primary Language:		Interpreter Needed: ☐ Yes ☐ No
School Name:	Grade:	Telephone: ( )
Does student currently receive mental health services? ☐ Yes ☐ No	If YES, Agency/Provider:	
Primary Care Provider Name:		Telephone: ( )

Responsible Party			
Name:		Relationship to Child:	
Address:			
Telephone:	Home: ☐ Preferred? ( )	Cell: ☐ Preferred? ( )	Work: ☐ Preferred? ( )
Do you need an interpreter? ☐ Yes ☐ No	If Yes, language:		

Primary Insurance Information (Please Provide Copy of Insurance Cards)	
Subscriber Name:	Relationship to student:
Insurance Carrier:	Policy #:
Employer:	

Secondary Insurance Information (If applicable)	
Subscriber Name:	Relationship to student:
Insurance Carrier:	Policy #:
Employer:	

Referral Source	
School:	
Name:	Title:
Phone:	E-mail:

School Based Mental Health AGENCY		
Agency Referred to: **(please check only one)**	☐ Arise ☐ Brownell	☐ St. Joes ☐ Syracuse Community Health Center
Referral Source Signature: ______________________________	Date: __________	

Reason for Referral

Please indicate why this referral is necessary:

☐ **Behavior Difficulties at School**	☐ **Grades are Impacted**	☐ **Other School Concerns**
☐ **Social Concerns at School**	☐ **Attendance Issues**	☐ **Family Concerns**

Check the specific areas of concern:

☐ Easily distracted	☐ Verbally threatening / aggressive
☐ Depressed mood	☐ Physically aggressive
☐ Poor / deteriorated hygiene	☐ Disruptive behaviors
☐ Mood swings	☐ Inappropriate language / gestures
☐ Anxious moods	☐ Inappropriate sexual behaviors
☐ Crying / tearfulness	☐ Destruction of property
☐ Anger outbursts	☐ Lethargic / sleeping in class
☐ Sudden change in mood or behavior	☐ Attention-seeking behaviors
☐ Parents divorce / separation	☐ Argumentative
☐ Out-of-home placement	☐ Disrespectful behaviors
☐ Suspected substance abuse	☐ Refusal to comply with rules / requests
☐ Homeless	☐ Excessive dislike of school
☐ Death of family / friend	☐ Excessive absenteeism
☐ Frequent somatic complaints	☐ Excessive tardiness
(Headaches, stomachaches, etc.)	☐ Failure to complete or return homework
☐ Isolates from peers	☐ Failure / refusal to complete tasks
☐ Recent withdrawal from friends	☐ Slipping grades / failure to perform at expected level
☐ Excluded by peers / lacks significant friend	☐ Bullied by others

Brief Description of Presenting Problem

Consent for Assessment

The Guardian of the above student is granting permission for ____________________________ _______________ (AGENCY) to utilize the above information provided to determine the appropriateness of mental health services for the child and to arrange for insurance billing of assessment and provided services. The guardian understands that they may be contacted by a representative of the AGENCY for any further information needed in order to process the referral and then by an AGENCY clinician once client status is established.

Parent / Guardian Print Name: _____________________________________

Parent / Guardian Signature:____________________________________ Date:___________