

## EXAMPLE - MENTAL HEALTH SERVICES SCREENING FORM

Name of Staff / Your Role: \_\_\_\_\_ Date: \_\_\_\_\_

School / Contact #: \_\_\_\_\_

Student Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Guardian Name / Contact #: \_\_\_\_\_

Primary Address: \_\_\_\_\_

Was a consent / release of information signed by the guardian provided with referral? \_\_\_ Yes \_\_\_ No

**(if no, please consult with guardian to obtain information and to obtain written consent before referral is submitted)** This is a voluntary referral. Guardian can choose to not receive mental health services and can seek out services with any provider.

Is student currently receiving mental health services? \_\_\_ Yes \_\_\_ No; If yes, what agency: \_\_\_\_\_

Does the student have an IEP? \_\_\_ Yes \_\_\_ No Does student have a 504 Plan: \_\_\_ Yes \_\_\_ No

**Please check if applies to current situation: (If yes, please seek out crisis services ASAP) 888-279-8616 and follow District Protocol for crisis situations.**

Imminent risk of harm to self or others *(please specify/explain): Has intent, plan and the means to act out intent – actively suicidal or homicidal (Complete Brief Suicide Screening)*

**Please check all that Apply / Reasons for Referral:**

**Attendance percentage:** \_\_\_  Repeated tardiness or truancy  Extreme mobility  Chronic Suspensions

**Academics:**  Retention  Low Achievement - chronic  Recent change in performance

**Social / Emotional:**  No friends  Being bullied  Bullying peers  Cries A lot  Sad / Withdrawn

Worries/Anxious  Anger outbursts  Overt Defiance  Self-harm threats or behaviors  Social Isolation

Recent / hx of psychiatric hospitalizations  Suicidal talk / writings  Substance use  Frequent Discipline Referrals

Homicidal Threats  Committed criminal acts

**Home Environment:**  Family member incarcerated  Basic needs not met  Victim of abuse or witness of abuse

Placed out of home  Medical Illness / issues  Pregnant or a parent  death of someone close to them

Mental illness in the home  substance use in the home

**Please list any other concerns or reason for referral:**

**Please list interventions / referrals (ie. Juvenile office / Children's Division) that have been explored to address concerns:**

**THIS SECTION TO BE BY SCHOOL'S MENTAL HEALTHvTEAM**

Date referral to School contact: \_\_\_\_\_ Initials: \_\_\_\_\_ Date Sent to MH Agency: \_\_\_\_\_ Initials: \_\_\_\_\_

Date of contact with guardian / parent: \_\_\_\_\_

Follow-up / Action taken:

**INSTRUCTIONS:**

1. Complete the **entire** form before submitting – be sure to include your name / role and contact information / and the date referral was submitted
  - a. Incomplete forms will only delay the referral process
2. Please ensure that a consent / release of information is attached **and** is signed by the guardian
  - a. The referral **cannot** be processed without a signed consent / release
  - b. **Parent / guardian has the right to not seek out services. This is a voluntary referral.** Parent / Guardian can seek out mental health supports or services at any provider they choose. They are **not required** to seek out services at TMCBH.
3. If the student is at **imminent risk** of harming self or others, follow school / district policy
  - a. Completing this referral is to access **outpatient mental health services only**, and **is not** for crisis situations
4. Please ensure that you are as detailed as possible in your reason for referral and the targeted behavior, including what has already been explored.
5. Once referral is completed, please provide to your school's assigned Social Worker or Behavioral Interventionist or OSI team member.