

SAMPLE SCHOOL-BASED BEHAVIORAL HEALTH REFERRAL FORM: SCHOOL STAFF

Name of student: _____ Student #: _____

Date: _____ Your name: _____

Relationship to student: _____

The school's school-based behavioral health team may wish to contact you to discuss your referral concerns. Please provide your contact information and the best time to reach you.

Phone: _____ Best time to contact: _____

Area of concern ((check all that apply and please describe):

- Academic Concerns: _____
- Behavioral Concerns: _____
- Social Concerns: _____
- Emotional Concerns: _____
- Physical Health Concerns: _____
- Family Concerns: _____
- Other: _____

Behavioral Concerns (please mark all boxes that apply):

- | | |
|--|--|
| <input type="checkbox"/> Exposed to community violence, other trauma | <input type="checkbox"/> Sad, depressed or irritable mood |
| <input type="checkbox"/> Nightmares, intrusive thoughts | <input type="checkbox"/> Hopelessness, negative view of future |
| <input type="checkbox"/> Anxious, fearful, or irritable mood | <input type="checkbox"/> Low self-esteem, negative statements |
| <input type="checkbox"/> Jumpy or easily startled | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Avoids reminders of trauma | <input type="checkbox"/> Diminished interest in activities |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Low or decreased motivation |
| <input type="checkbox"/> Sexualized play or behaviors | <input type="checkbox"/> Anxious and/or fearful |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Worries excessively |
| <input type="checkbox"/> Talks excessively | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Gets out of seat/moves constantly | <input type="checkbox"/> Restless and/or on edge |
| <input type="checkbox"/> Interrupts/blurts out responses | <input type="checkbox"/> Specific fears or phobias |
| <input type="checkbox"/> Inattentive, distractible, forgetful | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Disorganized, makes careless mistakes | <input type="checkbox"/> Clingy behavior |
| <input type="checkbox"/> Angry towards others or blames others | <input type="checkbox"/> Appears distracted |
| <input type="checkbox"/> Fights and/or is aggressive | <input type="checkbox"/> Argumentative and/or defiant |

How often is this behavior occurring? (e.g., several times per day; 1-2 times per week)

How long has this behavior been occurring? (e.g., several weeks, several months)

To your knowledge, what interventions have previously been tried?

In-school supports: _____

Outside of school supports: _____

To your knowledge, what interventions are currently in place?

In-school supports: _____

Outside of school supports: _____

What do you think will help the student to experience success?
