

## DMH Counseling Referral Form

Referred by:

Phone:

Email:

CONTACT THE PARENT/LEGAL GUARDIAN TO ADVISE THEM OF YOUR CONCERNS AND TO DETERMINE IF THEY ARE WILLING TO DISCUSS THEIR CHILD'S NEEDS WITH A MENTAL HEALTH COUNSELOR BEFORE MAKING A MENTAL HEALTH REFERRAL.

Name of Parent/Legal Guardian:

Phone:

Date:

Students Name:

SSN:

DOB:

Grade:

Parents/Legal Guardians:

Phone:

Cell:

Work:

**Student's Primary Needs** (Check all that apply)

- |                      |                 |                        |                   |
|----------------------|-----------------|------------------------|-------------------|
| Depressed            | Sad             | Self-Harming           | Anxious           |
| Family Relationships | Anger Outbursts | Defiant                | Sleeping in Class |
| Death of Loved One   | Victim of Abuse | Inattentive/Distracted | Low Self-Esteem   |
| Poor Decision Making | Mood Swings     | Peer Relationships     | Hyperactive       |

**Detailed description of reason(s) for referral** (attach additional information if needed):

**List classroom and Tier 2 strategies and interventions that have not been successful:**

**For Counselor's Use Only**

Contact Attempt 1:

Date:

Contact Attempt 2:

Date:

Contact Attempt 3:

Date:

Location:

Assessment Date: