



SBHC Behavioral Health Referral Form

Student: _____ Age: _____ DOB: _____
Last Name First Name

Home Address: _____
Street Apartment # City Zip Code

Home Phone: _____ Cell Phone: _____ Email: _____

REASON FOR REFERRAL (CHECK ALL THAT APPLY):

- Motivation Bullying Anxiety Stressed/Concerns Family/Home Life
- Divorce Fighting Worried Peer Relationships Drugs/Alcohol
- Friendship Absences Anger Destruction of Property Sadness
- Dishonesty Withdrawn Trust Values/Goals Social Skills
- Inattentiveness Death Fears Perfectionism
- Hyperactivity Stealing Lying Mandatory Counseling
- Other _____

Is student receiving counseling elsewhere? Yes No (If so, where: _____)

Housing: Good Poor None _____

Family Stress: Low Medium High _____

Known Exposures: Drug &/or Alcohol use in Home Domestic Violence Violence Incarceration

Other/More information: _____

Contributing Factors or Important Information:

Current behaviors &/or Concerns and reason for request:

Expectation or Desired Outcome from Individual Counseling Sessions:

NOTES: _____

The counselor may require additional information and regular communication while working with your student.

When/Where is the best times/location to connect with you?

Preferred days: (Please circle) Any Mon Tues Weds Thurs Friday

Best times: _____

Best Phone: _____ Email: _____