***School Based Behavioral Health Services***

**Referral Form**

Student Name: DOB:

Grade: School:

Insurance Plan: Insurance ID Number:

Referral made by: Referral Date:

Does the student have a **current** IEP? Yes No Section 504 Plan? Yes No

Reasons for Referral (Check all that apply):

| * suspected abuse, neglect, or exploitation * aggressive behavior toward others or self * suspected suicidal tendencies * bullying * problems with class work, homework, test grades * increased number of absences * decrease in social/interaction skills * inappropriate classroom/school behavior * assistance with obtaining school supplies * prolonged or frequent changes in affect (moodiness, anxiousness, sadness, weariness, anger, etc) * abrupt physical changes (tiredness, weight loss/gain, unexplained bruises, suspected substance abuse, etc) | * suspected homelessness * family issues that concerns the student * unable to contact parent * hygiene and appropriate dressing concerns * noted inability to focus * noted hyperactive behavior * suspected pregnancy/or teenage parent * home visit requested * other (please explain below) |
| --- | --- |

Is the student aware that you are making a referral? YES NO

Are the parents/guardians aware that you are making a referral? YES NO

Parents/guardians phone number:

Students address:

What United Family Center services/programs do you believe will best address your concerns (Check all that apply):

| * Behavioral Health Services   + Youth Recovery Programs   + Family Groups   + Alcohol & Other Drugs Assessments   + Family Services   + Individual Counseling   + Family Counseling   + Peer Support   + Coordinating Care   + Safety Evaluations |
| --- |

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***For United Family Center Staff Use Only:***

Date Received by UFC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Follow-Up:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_