Behavioral Health Services North: Child & Family Clinic
22 U.S. Oval Suite 100 Plattsburgh, NY 12903
(518) 561-1767 Fax (518) 561-1795
School-Based Mental Health Services Referral Form

Child:_____DOB:_____
Address:_____
Phone #:_____ Alternate #:_____ Permission to leave a message? Y N
Parent/Legal Guardian:_____

Child's School:_____ Grade:_____
Referral source:_____

Reason for referral:_____
_____
_____
_____

If known:
Pediatrician/PCP:_____
Current Medications:_____

Critical Indicators
Dangerous to self or others? Y N UK_____
Suicidal (thoughts, statements, attempts)? Y N UK_____
Trauma (physical/sexual abuse, domestic violence)? Y N UK_____
Fire setting? Y N UK_____
Abuse of animals? Y N UK _____
Risk of removal from home/family? Y N UK_____
Property damage? Y N UK_____
Self-control problems (attention, behavioral)? Y N UK_____
Functional impairment (school, family, self-care)? Y N UK_____
_____
Substance abuse? Y N UK_____
Psychotic symptoms (hallucinations, delusions)? Y N UK _____
Past psychiatric hospitalizations? Y N UK _____
History of (psychiatric) ER visits? Y N UK _____
Prior mental health services (provider) ? Y N UK _____
_____

Other:
Quality of school attendance? _____
Attitude towards school? _____
_____
Peer relationships? _____
_____
Relationships with teachers/staff? _____
_____
Other comments:_____
_____

Screening results attached? Y N Source: BASC SDQ PSC

Completed by: Date: