Morris Heights Health Center- School Based Health Centers
Mental Health Referral
Medical / Mental Health Integration Form

CONFIDENTIAL INFORMATION: Please hand this in directly to the Health Center Staff

Name: ____ D.O.B: ______________________________

School Name: _______________________________________ Grade/Class: ________________________

Name of parent/guardian: ____

Is the Parent/Guardian aware of referral to the SBHC? Yes ☐ No ☐

Parent Work phone #: ________________ Home #: _________________ Cell#: _____________________

Referral Source : ☐ School ☐ Self/Student ☐ Parent/Guardian ☐ Other: ____________________

Staff Person making the Referral to the SBHC: ____

Staff Role ____

For adolescents, what is best way to contact them (e.g. cell phone # or appt card): __________________

If you have specific concerns about the following, please escort student down to the health center for an assessment and speak to the medical provider immediately.

- Student's potential for injury to self and/or others (suicidal, homicidal, self-injurious behaviors)?
- Suspicion/Report of possible abuse/neglect:
- Altered mental status

Routine Referral to SBHC for Mental Health Services (you don't have to escort the student but let them know you made a referral to us)

This patient meets one or more of the following criteria for referral to the SBHC:

☐	Changes in Mood	☐	Severe Behavioral Problems
☐	Persistent, severe family difficulties	☐	Persistent, severe peer problems
☐	School refusal/truancy	☐	Severe academic problems
☐	Bereavement/grief/loss	☐	Other mental health concerns noticed

Please provide any details about the concerns checked above: ________________________________

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Staff Signature: _______________________________ Date: _____________________

Confidential

For Clinic Staff ONLY:

SW and Medical Provider consulted on this case on ______________________________
Date

_________________________________ _________________________________

SW Signature *Provider Signature*