MENTAL HEALTH SERVICES SCREENING FORM

Name of Staff / Your Role:___________________________________ **Date:**_______________

School / Contact #: ____

Student Name: ______________________________________ Age: _______ DOB: ____________________

Guardian Name / Contact #: ____

Primary Address: ____

Was a consent / release of information signed by the guardian provided with referral? ____Yes ____No
(if no, please consult with guardian to obtain information and to obtain written consent before referral is submitted) This is a voluntary referral. Guardian can choose to not receive mental health services and can seek out services with any provider.

Is student currently receiving mental health services? ____Yes ___No; If yes, what agency:_________________

Does the student have an IEP? ____ Yes ____No Does student have a 504 Plan: ______Yes _____No (**follow- up with Legal / Title 9)**

Please check if applies to current situation: (If yes, please seek out crisis services ASAP) 888-279-8616 and follow District Protocol for crisis situations.

☐ Imminent risk of harm to self or others *(please specify/explain): Has intent, plan and the means to act out intent – actively suicidal or homicidal (Complete Brief Suicide Screening)*

Please check all that Apply / Reasons for Referral:
Attendance percentage:____ ☐ Repeated tardiness or truancy ☐ Extreme mobility ☐ Chronic Suspensions

Academics: ☐ Retention ☐ Low Achievement - chronic ☐ Recent change in performance

Social / Emotional: ☐ No friends ☐ Being bullied ☐ Bullying peers ☐ Cries A lot ☐ Sad / Withdrawn
☐ Worries/Anxious ☐ Anger outbursts ☐ Overt Defiance ☐ Self-harm threats or behaviors ☐ Social Isolation
☐ Recent / hx of psychiatric hospitalizations ☐ Suicidal talk / writings ☐ Substance use ☐ Frequent Discipline Referrals
☐ Homicidal Threats ☐ Committed criminal acts

Home Environment: ☐ Family member incarcerated ☐ Basic needs not met ☐ Victim of abuse or witness of abuse
☐ Placed out of home ☐ Medical Illness / issues ☐ Pregnant or a parent ☐ death of someone close to them
☐ Mental illness in the home ☐ substance use in the home

Please list any other concerns or reason for referral:

Please list interventions / referrals (i.e. Juvenile office / Children's Division) that have been explored to address concerns:

THIS SECTION TO BE BY Problem-Solving Team

Date referral to School contact: ______ **Initials:** _____ **Date Sent to MH Agency:**________ **Initials:** ______

Date of contact with guardian / parent: _________

Follow-up / Action taken:

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MENTAL HEALTH SERVICES SCREENING FORM

INSTRUCTIONS:

1. Complete the **entire** form before submitting – be sure to include your name / role and contact information / and the date referral was submitted
   a. Incomplete forms will only delay the referral process

2. Please ensure that a consent / release of information is attached **and** is signed by the guardian
   a. The referral **cannot** be processed without a signed consent / release
   b. **Parent / guardian has the right to not seek out services. This is a voluntary referral**. Parent / Guardian can seek out mental health supports or services at any provider they choose. They are **not required** to seek out services at TMCBH.

3. If the student is at **imminent risk** of harming self or others, follow school / district policy
   a. Completing this referral is to access **outpatient mental health services only**, and **is not** for crisis situations

4. Please ensure that you are as detailed as possible in your reason for referral and the targeted behavior, including what has already been explored.

5. Once referral is completed, please provide to your school's assigned Social Worker or Behavioral Interventionist or OSI team member.

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