

**SHELBY COUNTY SCHOOLS MENTAL HEALTH CENTER (SCSMHC)**

STUDENT REFERRAL FORM

**Date**: Click or tap to enter a date.

**Person making Referral**: type here

**Student’s Name**: type here **Birthdate**:type here **Gender**: Male[ ]  Female[ ]

**School**:type here **Teacher**: type here **Grade**: type here **Room#**: type here

**Parent(s) Name**: type here **Phone #**: type here **Referred by**: type here

**Parent notified of Referral?** Yes [ ]  No [ ]

**REASON FOR REFERRAL:**

**Problem Type** (Check all that apply):

Disruptive Behavior [ ]  Hyperactivity [ ]  Verbal/Physical Aggression [ ]  Bullying [ ]

Bully Victimization [ ]  Abuse/Trauma [ ]  Depression/Sadness [ ]  Grief/Loss [ ]

Stress/Anxiety [ ]  Alcohol/Drug Use [ ]  Social Withdrawal/Rejection [ ]  School avoidance/Absenteeism [ ]

**Briefly describe the problem.** Please offer examples including severity, duration, and frequency:

 Click or tap here to enter text.

**Previous strategies for managing the problem** (e.g., parent conference, reprimands/discipline, being excused from activities, etc.): Click or tap here to enter text.

**Student /family strengths and weaknesses**: Click or tap here to enter text.

**Disposition of Referral (Completed by SCSMHC Staff ONLY)**

Tier I: Teacher/Classroom Consultation [ ]  Staff Education & Training [ ]  Parent Education [ ]

Tier 2: Behavior Intervention & Planning [ ]  Social-Emotional Learning Group [ ]

Tier 3: Individual Therapy [ ]  Group Therapy [ ]  Family Therapy [ ]  Functional Behavior Assessment [ ]

Referral to External Agency: Community Mental Health [ ]  DCS [ ]  Medical [ ]  Other: Click or tap here to enter text.

**Results/Comments:**