

**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:**