**Child and Adolescent Mental Health Services**

**Referral**

Last Name:       First Name:       Middle Initial:

Date of Birth:

Mailing Address:       City / State / Zip:

Physical Address:       City / State / Zip:

Student’s Cell:       Parent/Caregiver Name:      Parent/Caregiver Phone #:

Email:

Insurance:       Group #:

Who is completing this Referral:

School attended:

1. Is transportation to mental health services a barrier? [ ]  Yes [ ]  No
2. Has this student expressed a desire to die or no longer be alive? [ ]  Yes [ ]  No
3. If so, have you completed the school district crisis screening tool? [ ]  Yes [ ]  No
4. Do you think this student intends to hurt him or herself right now? Are you afraid to leave this student alone right now? If yes, immediate crisis assessment is required. Call Crisis Connections at 866-427-4747.
5. To your knowledge is this student using drugs or alcohol? [ ]  Yes [ ]  No
6. To your knowledge has this student experienced a recent trauma? [ ]  Yes [ ]  No

 Death of a loved one [ ]  Yes [ ]  No

 Abuse (sexual/physical/emotional) [ ]  Yes [ ]  No

 Divorce of parents [ ]  Yes [ ]  No

 Loss of home due to natural disaster [ ]  Yes [ ]  No

 Foster care or removal from family [ ]  Yes [ ]  No

1. How would you describe this students’ academic performance?

[ ]  Below Average [ ]  Average [ ]  Above Average

Attendance is a problem [ ]  Yes [ ]  No

**Primary Concerns, please check all that apply:**

***Depressive symptoms:***

[ ]  Depressed or irritable mood [ ]  Diminished interest in activities

[ ]  Weight loss or weight gain [ ]  Insomnia

[ ]  Fatigue or loss of energy [ ]  Feeling worthless or guilty

[ ]  Difficulty concentrating [ ]  Recurrent thoughts of death

***Anxiety Symptoms:***

[ ]  Excessive worry, feeling that something bad might happen

[ ]  Restlessness or feeling keyed up or on edge.

[ ]  Being easily fatigued.

[ ]  Difficulty concentrating or mind going blank.

[ ]  Irritability.

[ ]  Muscle tension.

[ ]  Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

[ ]  The anxiety, worry, or physical symptoms impair student from participating in events in school, in

 the community or at home.

***Behavior Concerns:***

[ ]  Often loses temper [ ]  Is often touchy or easily annoyed.

[ ]  Is often angry and resentful. [ ]  Argumentative/Defiant Behavior

[ ]  Often argues with authority figures or, for children and adolescents, with adults.

[ ]  Often actively defies or refuses to comply with requests from authority figures or with rules.

[ ]  Often deliberately annoys others.

[ ]  Often blames others for his or her mistakes or misbehavior.

[ ]  Has been spiteful or vindictive at least twice within the past 6 months.

***Trauma:***

[ ]  Directly experiencing a traumatic event or witnessing a traumatic event.

[ ]  Avoidance of or efforts to avoid people, places, conversations, or interpersonal situations that

 arouse recollections of the traumatic event(s).

[ ]  Substantially increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame,

 confusion).

[ ]  Markedly diminished interest or participation in significant activities, including constriction of play.

[ ]  Socially withdrawn or a decrease in positive interaction with others

[ ]  Increase in negative emotions such as guilt, shame, fear, confusion.

Does this student get along with their peers, have friends, make friend and keep friends?

On a scale of 1-10 please give an idea of student’s level of need? With 10 being most concerned for safety.

 1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 [ ]  6 [ ]  7 [ ]  8 [ ]  9 [ ]  10 [ ]  Unknown

Please include any additional information regarding students’ presentation/concerns or additional relevant information.

Is the student and caregiver aware and agreeable to a referral for mental health services?

Caregiver [ ]  Yes [ ]  No Student [ ]  Yes [ ]  No

# **Services that may be helpful to this student or family:**

[ ]  Individual Therapy (weekly meeting with a therapist)

[ ]  WISe (wrap around services/therapist/care coordinator/family peer/youth peer/most intensive

 services)

[ ]  Case Management (supportive service to assist with connection with community resources, skills

 training, parenting support)

[ ]  Drug/Alcohol Services:

[ ]  Parenting class or parenting consultation with therapist:

Instructions:

Please complete this referral to the best of your ability and make sure student and/or family have been notified and will be contacted.

Please email or fax this form to OBHC:

Email to: Esmerelda Gonzales, Referral Specialist at egonzalez@okbhc.org and Chris Lorz, at clorz@okbhc.org

Fax #: 509-826-3029

What can Child/Family expect:

We will make one attempt to reach this child/family once the referral form is received. If we are unable to reach them via phone or in person, we will send a letter to the home. After that we will close out this referral until the child/family reaches out for services.

We do have a limited # of slots at the school therefore we will triage students with the information you provided as well as reach out and speak with you if indicated. If no slots are available at the school, the student may be offered a therapist at OBHC or a telehealth provider or they may be placed on a wait list and provided with supportive services if applicable.

Students are also welcome to come to OBHC and request an enrollment packet and meet with an enrollment case manager to get the process started.

If you have any questions or concerns, please call Jackie Wiman, Director of Child and Adolescent Services at 509.826.8657.