# School Based Health Centers

## Referral for Services

**Fax 575-258-3320 - Phone 575-630-7974**

( ) Request for Professional Development
Topic _____
( ) Client Referral

Referred Client's Name _____ Date of Referral _____

Date of Birth_____ Social Security # _____

Address _____

Phone # _____ School Client Attends _____

Other community or school services client is receiving (JPPO, First Offenders, Behavioral Health Counseling…) _____

Client's Primary Care Provider _____

List all medications client is taking and the provider that prescribes them _____

_____

Client's Insurance _____

Parent/Guardian's Name _____ Is the parent/guardian aware of this referral? _____ Who has legal custody of the patient? _____

Presenting problems: _____

Client needs to be seen within: ( ) 24 hours ( ) 48 hours ( ) one week ( ) one month

Referred to _____ for _____

Referred by _____ Telephone # _____

Relationship to Client? _____

PLEASE TURN FORM OVER TO COMPLETE IMPORTANT INFORMATION!

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## Referral for Services

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**I give permission for medical records to be released to/from/exchanged with:**

( ) School Based Health Center

Name_____Agency_____Date_____
Name_____Agency_____Date_____
Name_____Agency_____Date_____
Name_____Agency_____Date_____

**All health information is confidential.** The purpose of this consent signature is to allow discussion and review of health information that specifically deals with or relates to an individual student. All parties agree that the information provided to them concerning the student shall be held in strict confidence. No party shall discuss the information he/she learned in any School Based Health Center meeting nor disclose it to any other person or entity unless proper authorization has been obtained through the School Based Health Center.

I ,_____, hereby authorize the School-Based Health Center to discuss and review medical information obtained in the course of diagnosis and treatment with:

Name_____Agency_____Date_____
Name_____Agency_____Date_____
Name_____Agency_____Date_____
Name_____Agency_____Date_____

Client Signature Date

**If the client is being referred for psychiatric services <u>only</u>, I agree to be responsible for the client's:**

( ) Follow-up counseling
( ) Medication management

_____
Provider Signature

*For Internal Use*

**Feedback**

PLEASE TURN FORM OVER TO COMPLETE IMPORTANT INFORMATION!