Meridian
BEHAVIORAL HEALTH SERVICES
Hope. Heal. Recover.

Send ALL Referrals to jacksonreferrals@meridianbhs.org

Referred by:_____ Student Name: _____

Referral Phone #: _____ Students DOB:_____

School:_____ Grade: _____ Teacher: _____

Parent/Guardian: _____ Home #: _____ Cell #: _____

Mailing Address: _____

Insurance (check one): ___Medicaid __Health Choice __Kanawa __BC/BS __Other Private Ins.: _____ ___None

Reason for Referral: **PLEASE COMPLETE THE CHECKLIST ON THE BACK OF THIS SHEET BEFORE SUBMITTING REFERRAL**

Has the school initiated and exhausted all in house interventions and resources for this student? ___ YES ___ NO

If yes, what are the presenting symptoms and how are these interfering with the student's academic, social and /or behavioral functioning? _____

_____

_____

Yes _____ No _____ Is this a suicide or threat assessment? Which one? _____

Yes _____ No _____ Parent is aware of the referral being made to Meridian Behavioral Health Services

_____ _____
Signature of Client or Guardian Date

****

By signing below, I give my permission for MBHS to release and/or receive my child's confidential information to/from

_____ . The Information to be released, shared, and exchanged will be concerning continuation of care.
Referral Source

Initiation of Services and the purpose of this release is for Continuation of Care.

- I understand that my information may not be protected from re-disclosure by the requester/recipient of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations (CFR 42, part 2), and the Health Information Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR, part 160 & 164 the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.
- I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits.
- I understand that I may revoke this authorization at any time. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

_____ _____ _____/_____/_____
Signature of Client/Guardian Relationship Date Signed

This release is valid for 60 days from the date of signature.

Please complete ONLY if you wish to revoke this authorization:

I,_____ am revoking this consent to release information, effective _____/_____/_____

_____
Signature of Client/Guardian

Referral Form: Meridian Behavioral Services

Name: _____ DOB: _____

Referring Person: _____

Reason for Referral: (Current concerns occurring within the past 30 days/check any that apply)

__Anger __Verbal/Physical Aggression __Academic Concerns

__Suicide/Homicide Behaviors __Depression __ Oppositional Behaviors

__Truancy __Anxiety __Substance Abuse

__Sexually Inappropriate Behaviors __Hyperactivity/Impulsivity

__Physical and/or Sexual Trauma __Hallucinations/Delusions (Circle Applicable Choice)

Please list details here: _____

_____

_____

_____

_____

_____

Medications: _____

Current Placement:

__Family Home __Group Home __PRTF/Hospital __Detention

__Foster Home __Relative Home __Homeless __Other

History of mental health treatment (What worked/what didn't?):

_____

_____

_____

Will the parents/caregivers engage in treatment? If not, what kind of assistance can the school provide to help?

_____

_____

Agency Involvement: (DSS___ DJJ___ Other_____)

If yes, please explain: _____

_____

_____