



Send ALL Referrals to referrals@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
Referral Source continuation of care.

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 I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.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: _____
