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| Student Name: |
| Student Date of Birth: |
| Student Grade: |
| Address: |
| Phone Number: |
| Parent’s Name: |
| Date Referral was received: |
| Date PHQ9 was administered: |
| PHQ9 Score: |
| Referral Date: |
| Referral Type: |
| Name of Organization & Program student is being referred to: |
| Date of most recent MH treatment: MONTH\_\_\_\_\_\_\_\_YEAR\_\_\_\_\_ |
| Number of months of untreated mental illness: |
| Number of years of untreated mental illness: |

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| Name of Student: | Date of Referral: |
| Parent Name: | Parent Contact #: |
| Referral Submitted By: |  |

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**Please indicate why this referral is necessary below**:

* Suicidal or history of suicidality
* Recent hospitalization
* Behavioral concerns
* Attention-seeking/reckless behavior
* Social/emotional concerns
* Isolation
* Academic concerns
* Family/home concerns
* Bullying

**Please indicate specific areas of concern below**:

* Persistent sad mood (i.e. crying, withdrawn)
* Verbalizes feeling hopeless/empty/sad
* Poor/deteriorated hygiene
* Lack of enjoyment in majority of activities
* Sudden, unintended weight loss/gain
* Persistently falling asleep in class
* Reports feeling worthless
* Talking/writing about death or suicide
* Self-harm behaviors (ex: cutting)
* Break up with girl/boyfriend
* Out of home placement
* Homeless
* Death of a family/friend
* Frequent somatic complaints unrelated to a medical condition (ex: headaches, etc.)
* Parent’s divorce/separation
* Withdrawing from friends and/or family
* Abusing drugs and/or alcohol
* Verbally/physically threatening/aggressive
* Victim of bullying/bullying others
* History of trauma (ex: physical, emotional, sexual abuse, violence, neglect, etc.)
* Overtly sexual behaviors
* Excessive worry and/or guilt
* Frequent angry outbursts
* Destruction of property
* Persistent irritable mood
* Marked decrease in concentration
* Sudden change in mood/behavior
* Life-threatening behaviors
* Excessive absenteeism/tardiness
* Slipping grades/not performing at grade level
* New transitions (ex: move, lifestyle change, etc.)
* Lacks coping/problem-solving skills
* Lack of support system
* Other:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Brief description of problem**:

*Please include any additional information about concerns, including relevant information about family, etc. in the box below:*

**CAPC USE ONLY**

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