cmmhc
Central Minnesota Mental Health Center
Together, Creating a Healthier Life

School Linked Mental Health Services Referral Form

Date of Referral:_____ Referral Source(s):_____

School Student Attends:_____

Student Identifying Information

Student's Name:_____ Date of Birth: _____

Race: _____ Hispanic/Latino Ethnicity: ◯ YES ◯ NO Gender: _____

County student lives in: _____ Grade/Primary Teacher: _____

Address:_____ City:_____ State:_____ Zip Code:_____

Billing Address (if different from above): _____

Parent or Guardian Name (please circle one): _____

Guardian Address: _____ Email: _____

Guardian Home Phone # (Cell)_____(Other)_____

Primary Care Provider: ◯ YES ◯ NO Dentist: ◯ YES ◯ NO

Emergency Contact Information (different from above): _____

Ok to leave a message: ◯ YES ◯ NO Text Reminder: ◯ YES ◯ NO

Phone #: _____

Reason for Referral

_____

_____

Existing Services for Student

1. Is the student on an IEP, 504 plan or being evaluated for educational assistance? ◯ YES ◯ NO

If yes, who are the student's primary special education staff members:_____

Once completed email to Sheri Tesch at stesch@cmmhc.com

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