



Beech Brook

School-Based Behavioral Health Referral

Date:

Student Name:	
Current School:	Grade:
Home Address:	Zip Code:
Phone Number:	
Parent/Guardian Name:	
Was Parent/Guardian notified of referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Insurance Type: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> No Insurance <input type="checkbox"/> I don't know	

Name & Title of Person Initiating Referral:	
Phone:	Email:

Check all the concerns you have about your child:

- Aggression** (arguing, forcing submission, bullying, fighting, stealing)
- Disruptive Behavior** (defiance, noncompliance (teacher/school), not following rules, out of designated area)
- Hyperactive Behavior** (tantrums, disturbing others, excess energy)
- Withdrawn Behavior** (prefer being alone, non-participation, unresponsive to social initiations, not talking with others)
- Depressed Mood** (overall sadness, low/restricted activity levels, crying, poor appetite)
- Unassertiveness** (shy, being timid, not standing up for one's self)
- Anxiety** (acting in a fearful manner, appears overly stressed, inability to cope with daily functioning)
- Other:** _____

Please describe the reason for completing this referral:
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