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| Cottonwood Main Location8E Cottonwood St.Cottonwood, AZ 86326877-634-7333Fax: 866-984-3891 |

SCHOOL Referral for Spectrum Healthcare Integrated Services

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| --- | --- | --- | --- | --- | --- |
| **REFERRAL INFORMATION** | | | | | |
| Date of Referral | | |  | | |
| Name of School and District | | |  | | |
| School Personnel Making Referral | | |  | | |
| Relationship to Client | | |  | | |
| Contact Phone | | |  | | |
| Contact Email | | |  | | |
| **STUDENT/CLIENT INFORMATION** | | | | | |
| Student Legal Name/Preferred Name if applicable | |  | | | |
| Student Phone Number | |  | | Date of Birth |  |
| Assigned Birth Gender and/or preferred gender pronoun if applicable |  |
| Student E-mail | |  | |
| Primary Language  Secondary Language | |  | | | |
| A. Parent/Guardian Name | |  | | | |
| A. Phone Number/email | |  | | | |
| B. Parent/Guardian Name | |  | | | |
| B. Phone Number/email | |  | | | |
| Address of Student Residency | |  | | | |
| **REASON FOR BEHAVIORAL HEALTH SERVICES REFERRAL** | | | | | |
| *Briefly describe any challenges or difficulties the student has been experiencing over the last 3 months:*  *What interventions have been tried in the last 3 months?* | | | | | |
| [**EMAIL COMPLETED FORM TO referrals@spectrumhg.org**](mailto:EMAIL%20COMPLETED%20FORM%20TO%20referrals@spectrumhg.org) | | | | | |
| **INTERNAL SHG USE ONLY** | | | | | |
| Date Received |  | | | | |
| Outreach | 1st 2nd 3rd | | | | |
| Intake Date |  | | | | |