COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

Referral for SchooLink Services

SchooLink

Enter School Name

Select Skill Building SchooLink Provider	Select Core SchooLink Provider	Select TRC SchooLink Provider
Phone:	**Phone:**	**Phone:**
Fax:	**Fax:**	**Fax:**

1. STUDENT INFORMATION			Date of Referral:
Student Name:	Date of Birth:		Ethnicity:
Gender Identity: ☐ Male ☐ Female ☐ Non-Binary ☐ Prefer Not to State			
Type of Insurance: ☐ Medi-Cal Number:		☐ No Insurance ☐ Other Insurance:	
Grade:	Teacher:	Individualized Education Program (IEP) ☐ YES ☐ NO	Behavioral Health Services on IEP: ☐ YES ☐ NO
Who is providing consent for the SchooLink referral? ☐ Legal Guardian ***OR*** ☐ Student (Student must be 12 years or older and request to self-consent under parameters outlined in the SchooLink Module for Consent.)			

2. HOW HAS CONSENT BEEN PROVIDED FOR THIS SCHOOLINK REFERRAL?	
☐ Written consent obtained by Legal Guardian* or Student	(Attach Authorization for Use or Disclosure of Information)
☐ Verbal consent provided to Staff by Legal Guardian* or Student	(Staff to complete attestation below)
➢ Staff Name:	
➢ Date Staff Obtained Verbal Consent:	
➢ Staff Signature:	

*Complete Section 3 with Legal Guardian Information.

3. LEGAL GUARDIAN INFORMATION	
Legal Guardian's Name (who provided consent):	
Address:	
Phone:	Email:
Guardian Preferred Language:	Student Preferred Language:

4. REFERRING PARTY INFORMATION	
Referring Party Name and Title:	
Phone:	Email:

5. REASON FOR REFERRAL					
☐ Mood	☐ Substance Use	☐ Family Concerns	☐ Changes in Behavior	☐ Social-Emotional	☐ Other:
Comments:					