Date of Referral: _____

Print Form | Clear Form

Counseling Services of Southern Minnesota

SLMH PARENT/GUARDIAN REQUEST FOR SERVICES FORM

Fax Completed Form to Attention: SLMH Intake Department at 507-931-8060

Steps for completing a request for School Linked Mental Health Services

1. Explain to caregiver the nature of the referral (i.e. what/why you are requesting services)
2. Confirm that student does not already receive mental health services (provided by a counselor/therapist/psychologist) or reason for wanting to transfer care
3. Obtain a Release of Information signed by the caregiver who has legal custody and signed by you as the witness

Options for referral (Check the following that should apply)

- ☐ Caregiver is interested in learning more about the services provided by CSSM and would like a call from a therapist
- ☐ Caregiver wants to start services and would like a call from our intake department to schedule an intake/assessment
- ☐ Information was given to the parent/caregiver and they will contact CSSM if they decide to pursue services

Student Name: _____ **Referring Staff/Title:** _____

Date of Birth: _____ **Age:** _____ **Referral Source Phone:** _____

Sex: _____ **Best Time(s) to schedule during school:** _____

Grade: _____ **School Site Student Attends:** _____

Reason for Request (please describe in detail the concern or problem):

_____

_____

_____

Parent(s)/Guardian Information #1

Name(s): _____ Phone #: _____

Address: _____ Email: _____

_____

Parent(s)/Guardian Information #2

Name(s): _____ Phone #: _____

Address: _____ Email: _____

_____

****In cases where parents are separated/divorced, information will be requested regarding legal custody of minor referred during intake****

Does student have healthcare insurance? ☐ **Yes** ☐ **No**

(If yes, insurance information is required to be provided prior to or at the start of services; Grant funding may be available for students / families with no insurance or financial concerns; options will be discussed during intake)

Insurance Name: _____ ID Number: _____ Group Number: _____

Policy Holder Name and contact info (if not provided above): _____

Policy Holder Date of Birth: _____ Does Student have Secondary Insurance? ☐ **Yes** ☐ **No**

My Signature below indicates consent to be contacted by CSSM to discuss potential services:

Parent/Guardian Signature: _____ **Date:** _____

Student Signature (18+): _____ **Date:** _____

Witness/Referral Source Signature: _____ **Date:** _____