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School-Based Health Centers
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 Jennings School District
 Ritenour School District
 Riverview Gardens School District

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For more information visit...
www.carestlhealth.org

School-Based Behavioral Health Referral Form

Student Information

Student: _____ DOB: _____ Grade: _____

School: _____ Referred by: _____ Date: _____

Parent/Legal Guardian: _____ Phone: _____

Does student currently receive counseling services from another provider? Y N If yes, student is unable to receive services at this time.

Has parent/legal guardian been informed of the presiding issue and that a referral has been made? Y N If no, provide reason for no contact:

Reason for Referral

- | | |
|--|--|
| <input type="checkbox"/> Behavior difficulties at school
<input type="checkbox"/> Mental health diagnosis
<input type="checkbox"/> Social concerns | <input type="checkbox"/> Family concerns
<input type="checkbox"/> Recent loss due to death (who/when)
<input type="checkbox"/> Recent loss due to divorce/separation |
|--|--|

Check the specific areas of concern (all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> depressed mood
<input type="checkbox"/> anxious mood
<input type="checkbox"/> sudden change in mood
<input type="checkbox"/> disruptive behaviors
<input type="checkbox"/> attention-seeking behaviors
<input type="checkbox"/> crying/tearfulness
<input type="checkbox"/> excessive tardiness
<input type="checkbox"/> excessive absenteeism | <input type="checkbox"/> self-harm
<input type="checkbox"/> recent suicide attempt (s)
<input type="checkbox"/> suicidal ideation
<input type="checkbox"/> sexual behavior
<input type="checkbox"/> sleeping in class
<input type="checkbox"/> refusal to work
<input type="checkbox"/> excessive dislike of school
<input type="checkbox"/> declining grades | <input type="checkbox"/> defiance
<input type="checkbox"/> anger outbursts
<input type="checkbox"/> aggression
<input type="checkbox"/> destruction of property
<input type="checkbox"/> isolates from peers
<input type="checkbox"/> bullied by others/bullying others
<input type="checkbox"/> peers share concern
<input type="checkbox"/> other _____ |
|--|--|--|

Brief description of specific concern (s): _____

Interventions Attempted Prior to Referral

- | | |
|---|---|
| <input type="checkbox"/> Conference with student
<input type="checkbox"/> Refer to principal, counselor, nurse
<input type="checkbox"/> SSD services
<input type="checkbox"/> Progress reports | <input type="checkbox"/> Conference with parent
<input type="checkbox"/> Time out
<input type="checkbox"/> Talk to previous teacher/specialist
<input type="checkbox"/> Suspension |
|---|---|

Existing Support Services

- | |
|--|
| <input type="checkbox"/> Individualized education plan
<input type="checkbox"/> Behavior intervention plan
<input type="checkbox"/> 504 plan
<input type="checkbox"/> Other _____ |
|--|

Additional comments and/or caretaker concerns (e.g. existing diagnosis/medications, current/previous services with psychiatrist, etc.) : _____

Please complete and attach the Strengths & Difficulties Questionnaires completed by staff and caretaker. All referral information must be completed and additional documents must be submitted for processing.

Any questions, comments, or concerns, please contact Jasmine Burris by phone 314.882.1284 or email: jbarris@carestlhealth.org