**SCHOOL DISTRICT REFERRAL FORM**

|  |  |
| --- | --- |
| Name of Student |  |
| DOB |  |
| Referring School |  |
| Referring District |  |
| School Address |  |
| Phone |  |
| Fax |  |
| Name & Title of Person Making Referral |  |
| Email and/or Fax to Send Completed Assessment:  |  |

[ ] **School Clearance Assessment** [ ] **Substance Evaluation & Treatment**

**Reason for Referral:** Please include all pertinent information regarding student’s substance use and any written material by student and reports by staff regarding the incident. Include date and time incident occurred:

|  |
| --- |
|  |

**History & Additional Information:** (including any changes in behavior, academic performance, family, dynamics, agencies involved with student/family, known mental health or substance abuse concerns in the past, past school clearance assessments):

|  |
| --- |
|  |

|  |  |
| --- | --- |
| . |  |

Signature of Referring Person DATE