**SCHOOL DISTRICT REFERRAL FORM**

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| 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:

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**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):

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Signature of Referring Person DATE