



SCHOOL DISTRICT REFERRAL FORM

Name of Student	
DOB	
Referring School	
Referring District	
School Address	
Phone	
Name & Title of Person Making Referral	
Email Completed Assessment to:	

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):

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Signature of Referring Person

DATE

Upon Completion **EMAIL:** intake@tcbllc.org
Referral forms must be received **PRIOR** to a parent contacting us to schedule an appointment.