Tri-County Behavioral Care
DENVILLE HACKETTSTOWN SPARTA WAYNE
973-691-3030 — tcbllc.org

SCHOOL DISTRICT REFERRAL FORM

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

Select All That Apply:

☐**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

Upon Completion **EMAIL:** intake@tcbllc.org

Referral forms must be received **PRIOR** to a parent contacting us to schedule an appointment.

CALL: Monday-Thursday 10am-6pm and Friday 9am-5pm 973-691-3030 x 1

7/12/2022