**SCHOOL CLEARANCE ASSESSMENT REFERRAL FORM**

| Name of Student |  |
| --- | --- |
| DOB |  |
| Grade |  |
| Referring School |  |
| Referring District |  |
| Parent/Guardian Contact Name |  |
| Parent/Guardian Address, City, State and Zip Code |  |
| Parent/Guardian Number |  |
| Parent/Guardian Email |  |
| Name & Title of Person Making Referral |  |
| Email the Completed Assessment to:  |  |

Select All That Apply:

**☐School Clearance Assessment ☐Substance Evaluation & Treatment**

| **HIGH RISK EVALUATION:**  | YES | NO | UNSURE |
| --- | --- | --- | --- |
| Actively engaging in self-harm or physical aggression toward others. |  |  |  |
| Suicidal or homicidal plans with intent (within the past 7 days). |  |  |  |
| Made any suicidal or homicidal attempts (within the past 7 days). |  |  |  |

**STOP** if the answer to any of these questions is **YES**.  The above criteria are likely indicative of needing a higher level of care than Tri County Behavioral can provide at this time. The student is to be sent to the nearest Emergency Room for psychiatric evaluation for the safety of the student and others. *If unsure, please contact us as we will provide consultation regarding the referral.*

**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