



**Student Health and Advanced Resources for Education**

JBS Mental Health Authority Children's Services  
School Based Therapy  
**Referral Form**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Alt phone#: \_\_\_\_\_

School: OES \_\_\_\_\_ OMS \_\_\_\_\_ OHS \_\_\_\_\_ Grade: \_\_\_\_\_

On Grade Level: Y / N Placement/ IQ: \_\_\_\_\_

Parent/ Guardian: \_\_\_\_\_

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Others living in home	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Agencies Involved (DHR, Juvenile Court, Mental Health, etc.)  
\_\_\_\_\_

Present situation/ Concerns:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referred by: \_\_\_\_\_ Contact #: \_\_\_\_\_