For Urgent Referrals: **Phone: (315) 405-7444**	**For NonUrgent Referrals:** **Phone: (315) 788-7430** **Fax: (315) 779-1184** **Email: cslp@chjc.org**

Referral Form for Community School Liaison Program

DEMOGRAPHICS

Name (Last, First, MI):	**Date of Birth:**
Gender Preference:	**School District/Grade:**
Address:	**Phone:**

CAREGIVER INFORMATION

Caregiver #1:		**Caregiver #2:**	
Relationship to Child:	**Legal Guardian:** ☐ Yes ☐ No	**Relationship to Child:**	**Legal Guardian:** ☐ Yes ☐ No
Address (if different from youth):		**Address (if different from youth):**	
Phone:		**Phone:**	

CONSENT TO REFER *Consent to make this referral must be obtained from the parent/guardian/legally authorized representative up to the age of 18. Children/Youth ages 18-21, or those who are married, a parent, or pregnant, may consent on their own behalf. *If signed by legal guardian, please provide guardianship documentation.**

Name of Consenter:	**Signature:**	**Date:**

Reason for Referral

Check all that Apply:	**Additional Notes:**
☐ Experiencing mental health crisis in school setting ☐ Experiencing mental health crisis in home setting ☐ Behavioral concerns in school setting ☐ Behavioral concerns in home setting ☐ Connection to community-based services ☐ Other (please specify):	

INSURANCE

Name of Insurance Company:	**Medicaid CIN (if applicable):**

CURRENT PROVIDERS

Therapist/Agency:	**Psychiatrist/Agency:**
Other Provider/Agency:	**Other Provider/Agency:**

REFERRAL SOURCE

Name/Title:	**Organization:**	**Date of Referral:**
Phone:	**Email:**	