Referral Date: _____

Longfellow Alternative High School
Referral for School-Based Mental Health Services

Student's Information:

Name_____

Birthdate _____ Age _____

Address _____ Phone # _____

_____

Advisor at LHS _____

Referral Source _____ _____
Name Phone number

Reason for Referral _____

_____

Parent/Guardian's Information (if applicable):

Name _____ Phone # _____

If student is ***under 18*** years old, has parent/guardian consented to mental health services for student? YES NO

*****Please return to School Social Worker*****

Follow-up Action (for therapist's use only)

Date Action Outcome