NORTHSTAR LEARNING CENTERS, INC.
MENTAL HEALTH OUTREACH PROGRAM

Referral Form for Mental Health Services

Date of first contact: ____

Participant Information

Please check: Is this a PR Relief youth/family □ yes □ no

Name:	Date of Birth:	Race/Ethnicity:
I identify my gender as: ❒ Male ❒ Female ❒ Trans* ❒ Non-binary/non-gender conforming		
School & Grade:		
Services Requested: ❒ Office-Based Outpatient ❒ School-Based (if therapist is available)		
Best Contact Numbers:	Can we leave a message? ❒ Yes ❒ No	
Address:		

Parent or Legal Guardian Information (If participant is under 18 years old)

Name of Parent or Legal Guardian:	Address:
Best Contact Numbers:	
Type of setting: ❒ Home ❒ Group Home ❒ Foster Home ❒ Psychiatric hospital ❒ Other	

Insurance Information:

Type of Insurance: ❒ Medicaid ❒ BCBS ❒ Other	Group#
Insurance ID#	Phone #

Referral Source Information (Complete this section so we can contact you after the referral is made).

Name:	Mailing Address:
Phone#:	Email address:
If in-house referral, what program:	

Child/Adult Mental Health Information

Current medications & dosages:	Current DSM-V Diagnosis, if known:
1)	
2)	
3)	
Prescribing Physician's name & phone:	

Current Mental Health Symptoms:	Unknown	Not Present	Mild	Moderate	Severe
Antisocial / delinquent behavior / conduct disorder					
Oppositional / defiant to those in authority					
Hallucinations (describe)					
Delusions					
Thought disorder					
Bizarre (psychotic) behavior (describe below)					
Anxiety / Nervousness					
Obsessive / compulsive					
Phobias / fears					
Depressed mood					
Mood swings					
Sleep disturbance					
Irritability					
Anger / temper tantrums					
Hyperactivity					
Attention deficit					
Eating problems					
Elimination problems					
Over sexualized behavior					
Somatic complaints with no known medical cause					
Attachment disorder (explain below)					
Other (explain)					

Reason for referral for treatment: In your own words, describe the child/adult in need for mental health services. Please describe specific behaviors the child/adult is exhibiting.

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Additional Comments ____

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Been in counseling before? ❒ Yes ❒ No

Availability: ❒ Morning ❒ Afternoon ❒ Evening

Best day of the week: ❒ Mon. ❒ Tues. ❒ Wed. ❒ Thurs. ❒ Friday

Counselor Preferences:____