Referral Form

SOUND
The forefront of behavioral healthcare

For students under 13, parental consent for us to schedule an intake must be given prior to referral. For students 13 and older, parental consent is not required, but is preferred.

Referral Source (name, school, and contact information):_____

_____

_____

Referral is for (check all that apply):

☐ Mental Health Services

☐ Chemical Dependency (CD) Assessment*

*If referral is for CD assessment, is student on suspension for a substance related matter?

☐ Yes ☐ No

Student Name:_____

Date of Birth:_____

Provider One # (if known) or Insurance:_____

Parent/Guardian Name(s) and Relation to Student: _____

Best number to contact family:_____

Email: _____

Address, City, and Zip Code: _____

_____

Should address be kept confidential? ☐ Yes ☐ No

Primary Care Physician or clinic name (if known): _____

Has student/family agreed to mental health/CD services? ☐ Yes ☐ No

Reason for referral (behaviors, significant events, changes in mood, etc.):_____

_____

_____

Comments/other info:

_____

_____

_____

_____

Please email or give this form to the Sound counselor at your school or fax to 206-444-3610. Thank you!