Resize font:
⊞ | ⊟

↻ **Returning?**

UR SOS
UR Supporting Our Students

What service is this referral for?
* must provide value

☐ **START:** Short Term Assessment & Referral Team (Up to 6 sessions focused on crisis response, safety planning, and stabilization)

☐ **READY** For Treatment Program (Up to 12 skill-based sessions with family involvement)

Is this child currently receiving outpatient psychiatric services, therapy, or counseling?
* must provide value

○ Yes
○ No

reset

Have parents been contacted regarding this referral?
* must provide value

○ Yes parents have been contacted regarding this referral, and agree to being contacted by UR Medicine Pediatric Behavioral Health & Wellness.

○ No (Note: Referral cannot be processed without parent collaboration and collateral).

reset

Please upload a signed release of information to Pediatric Behavioral Health & Wellness.
* must provide value

⬆ Upload file

Due to COVID-19, documentation of verbal consent is acceptable on the school's regular Release of Information form.

Referrer's Contact Information

Referrer's Name
* must provide value

Referrer's E-mail
* must provide value

Primary School Contact for This Student

e.g., Case manager

Relationship to Student

Primary School Contact's E-mail

Referrer's District
* must provide value

Child's Information

Child's Name
* must provide value

Date of Birth
* must provide value

📅 | Today | M-D-Y

Address: Street, City, State, ZIP
* must provide value

Expand

School
* must provide value

Grade

District
* must provide value

Does this student have an IEP or 504 plan?

○ Yes
○ No

reset

Insurance Information (if available):

We ask this because not all insurances include UR Medicine as an in-network provider for behavioral health services.

Pediatrician or Family Medicine Provider/Practice

This information is helpful for future collaboration with the student's primary care provider.

Family/Guardian Contact Information

Parent/Guardian #1:
* must provide value

Parent/Guardian #2

Primary Phone Number for Scheduling
* must provide value

Include Area Code

Alternative Phone Number

Include Area Code

Referral Information

Reason for Referral
* must provide value

☐ Academic Concerns
☐ Behavioral Concerns
☐ Attendance Concerns
☐ Social Concerns
☐ Emotional Concerns

Please rate the urgency of this request
* must provide value

Not urgent   Moderately urgent   Very urgent

Change the slider above to set a response

reset

Please describe the presenting problem necessitating a referral. In your response, please include:

- Significant emotional or behavioral health difficulties
- Teen's, parents', and school's primary concerns related to these difficulties
- Duration of challenges
- Readiness for intervention

must provide value

Expand

Most responses are typically 4 - 5 sentences.

Has this child had any previous behavioral health treatment?

○ Yes
○ No

reset

Safety Screen

Please note that this form is not monitored live. If you have immediate concerns, please contact LifeLine, 911, or the Monroe County Mobile Crisis Team at 585-275-5151.

Does this child use alcohol or substances?   ○ Yes   ○ No

must provide value

reset

Is this child at immediate risk for harming themselves or others?   ○ Yes   ○ No

must provide value

reset

Has this child done anything to harm themselves in the past 30 days?

must provide value

○ Yes
○ No

reset

Please indicate any additional resources discussed with families:

☐ Life Line (2-1-1)
☐ Mobile Crisis (585-275-5151)
☐ UR Medicine Behavioral Health Crisis Call Line (585) 275-8686
☐ Police (9-1-1)
☐ Emergency Dept. Information
☐ Connection with Pediatrician or Family Medicine Provider
☐ County provider (e.g., FACT, SPOA)
☐ Other (specify)

Any Additional Comments or Concerns?

Expand

Submit

Save & Return Later