Emergency Mental Health Referral

Today's Date: Time:

Referral to:

Please type or print clearly:

Student Legal Name:	D.O.B.
Other name student may go by?	Gender: ☐ M ☐ F ☐ Other
Address:	Grade:
Parent/Guardian #1: Relationship: Lives with child? Y or N	Contact #:
Parent/Guardian #2: Relationship: Lives with child? Y or N	Contact #:
Home School District:	
BOCES 2 school program and location:	Fax #:
Teacher Name:	Contact #:
BOCES 2 Mental Health providers name/title: Email:	Contact #:
Brief description of concern:	
Any significant alerts that receiving staff should be aware of?	
School staff member who contacted parent: Additional comments?	
BOCES 2 Staff member completing this form: (Print Name/Title)	

Consider attaching: Emergency Medical Form and Health History (include any standing physician orders) and/or Confidential Student Information notes page

<u>BOCES staff</u> to give this form to mobile crisis, ambulance or parent for them to provide to Hospital/Crisis staff. Place copy in student Medical File within Records Dept.

Notify Program Supervisor, BOCES Nurse, BOCES MH, and place call to receiving site.