Clinton Public Schools
Department of Special Services

Community Health Clinic Referral Form

Student Name: _____ School: _____

Grade: _____ Current status: ☐ SRBI ☐ 504 ☐ IEP ☐ N/A

Referral Source: ☐ Parent ☐ SAT/CST ☐ School Social Worker/School Psychologist

Referral Source's Name: _____

Reason for Referral:

☐ Behavior Problems ☐ Family Changes ☐ Personal Problems

☐ Crisis ☐ Peer Relationships ☐ Depression

☐ Anxiety ☐ Other

Please explain concerns and reasons for referral in detail:

Other services received in the school and/or community:

The student's parent(s)/guardian(s) must be contacted prior the making a referral.

Date when permission for referral was received: _____

Name of SBHC clinician: _____

Date Referral Addressed: _____

Action Taken: _____