School Based Therapy and Youth Services Referral Form

Referrer Contact Information	
Today's Date _____	**Name of Referrer** _____
Referrer Contact Information (Phone Number/Email Address) _____	

Please attach a release of information

Client Information			
Name _____ **Grade:** _____	**Date of Birth** _____	☐ Female ☐ Male	
Address _____	**City** _____	**State** _____	**Zip Code** _____
Phone Number: _____ **SSN:** _____	**Insurance Provider (if known)** **MCO:** ☐ Amerigroup ☐ IME ☐ Iowa Total Care ☐ **Other** (BCBS, private insurance): _____ **Legal Documents:** _____		
Guardian: ☐ Yes ☐ No (*If Yes, please provide name and phone number below.*) | **Foster Care:** ☐ **Yes** ☐ **No**			
Guardian Name(s) & Phone Number _____			

Service Information
Service Requested ☐ BHIS ☐ YSW ☐ Therapy ☐ RPG ☐ Consultation
Have the child's parent/guardian been contacted about services through Seasons? ☐ Yes ☐ No
What interventions have been used? ☐ SELF/RE-Set Room ☐ Guidance ☐ Small Groups ☐ Behavior Charts
☐ Other: _____
Special considerations (i.e. Special Ed Services, DHS, Do not contact certain person, etc.
What is the reason for referral (list behaviors/symptoms)?

Completed form and release can be emailed to ccsdreferrals@seasonscenter.org

Office Use Only:
Completed By: _____ Date: _____
Assigned To: _____ Appointment Scheduled for: _____

Parents Were Contacted ____
Parents Did Not Respond _____
Parents Refused _____