FERNBROOK Family Center
P.O. Box 977 Owatonna, MN 55060
Phone: (507) 446-0431 Fax: (651) 925-0337 Email: info@fernbrook.org

Referral for School-Based Mental Health CTSS Services

Name of Referral Source: _____ Role:_____

Email: _____

I am referring the following student for school-based mental health services:

Student Name:_____

Resident District Name and Number: _____

Date of Birth: _____ Age:_____ Grade:_____

Parent/Guardian Name (1):_____

Address:_____ Phone:_____

_____ Email:_____

Parent/Guardian Name (2):_____

Address:_____ Phone:_____

_____ Email:_____

Please list key concerns/barriers to service that the student/family is experiencing:

- ☐ Academic challenges
- ☐ Behavioral (e.g. acting out, etc.)
- ☐ Disengagement from school (e.g. not participating in class activities, leaving classroom, truancy, etc.)
- ☐ Emotional challenges (e.g. depression, moody, etc.)
- ☐ Engaging in risky behavior (e.g. using drugs/alcohol, shoplifting, getting into fights, vandalism)
- ☐ Substance abuse
- ☐ Truancy
- ☐ Other. Specify: _____

Please provide additional information about student's current difficulties (i.e. onset of concerns, frequency of behavior, triggers for behavior, etc.)

_____
_____
_____
_____
_____
_____

Please list interventions previously tried, date tried, and the results of those interventions.

_____
_____
_____
_____
_____
_____
_____

Interpreter/translator required (specify language): _____

Has the student received mental health services:

- ☐ Yes
- ☐ No
- ☐ Unknown

Date of Expected Entry: _____