School-MHW-Referral (Mental Health Wraparound)

Identify: ________________________ School Corporation

Return to: County Office/ Child and Family Services
460 S Spring St, Jeffersonville, IN 47130
Ph: 812-206-1416 Fax: 812-206-1410

Date: _______________

Have parents been contacted regarding services? Yes__________ No__________

School: __________________________ Teacher:______________________________

Is the child receiving special education services? Yes___________ No____________

Referral Source/Contact Person: ____

Child's Name: _______________________________________ Date of Birth ______________________

Parent's Name(s): ____

Address: ____

Phone: __________________________________ Insurance: Yes___________ No___________

Reason for Referral: ____

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Interventions attempted at school: ____

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Interventions attempted in home and/or community: ______________________________________

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I give ________________________ School Corporation Personnel permission to refer my child for services with LifeSpring Health Systems Team. I understand that a staff member from LifeSpring will contact me. I agree to release the above information to the LifeSpring personnel in order to obtain services for my child.

Parent Signature ____ Date______________________