School Referral *for* OP Mental Health Services LSHS

Identify: _____ School Corporation

C/O: 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___ Type:_____

Reason for Referral:

Suicidality: ___ Self-Harm: ___ Residential/Hospital Discharge: ___ Aggression: ___

Abuse/Neglect: ___ Substance Use: ___ Legal Involvement: ___ Trauma: ___

Comments:_____

_____

_____

Interventions attempted at school: _____

_____

Interventions attempted in home and/or community: _____

_____

Client Openness to Services: High ___ Moderate ___ Low ___ Refuses ___

I give New Albany Floyd County 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_____