Safe Schools Healthy Students
7120 I-40 West, Suite 260 – Amarillo, Texas 79106
806-326-1355

Date: _____

The Referral is:

☐ Emergent (intervention within 1 calendar day)
☐ Urgent (intervention within 3 Calendar days)
☐ Routine (intervention within 4 Calendar days)

REFERRING PROFESSIONAL:

Name: _____

Position: _____

School: _____

Contact Number: _____

☐ Check if Parent has been contacted
☐ Check if Administrator has been contacted

STUDENT INFORMATION:

Name: _____

School/Grade: _____

Parent/Guardian: _____

Address/Zip: _____

Contact Number(s) : _____

REASON FOR REFERRAL:

☐ Suicidal ideation or threats	☐ Cutting/harm to self	☐ Habitual Behavior Issues
☐ Threats to others	☐ Depression	☐ Change in Behavior
☐ Drug/Alcohol	☐ Family Conflict	☐ Bullying issues
☐ Grief	☐ Gang Affiliation	☐ Other _____

Please give as much detailed information as possible for MHP to access the situation

---

TO BE COMPLETED BY CLUSTER MHP: Date received: _____

Follow Up Dates: _____ _____ _____ _____ _____

Did you complete a family needs assessment? ____ Yes ____ No

Did you complete a mental health assessment? ____ Yes ____ No If yes, did parent sign consent? ____ Yes ____ No

Recommend student to receive services from:

____ AISD Mental Health Professional ____ TPMHMR, 354- 2191 ____ Others

Name of Agency	Phone Number
_____	_____
_____	_____
_____	_____

____ Family Accepted Services ____ Family Declined Services