CHESTNUT RIDGE
COUNSELING SERVICES, INC

SCHOOL BASED OUTPATIENT SERVICES
EXTERNAL REFERRAL

DATE OF REFERRAL: _____

NAME: _____ **DOB:** _____ **GENDER:** _____

ADDRESS:_____ **PHONE#:** _____

SCHOOL: _____ **GRADE:** _____ **IEP/504:** ☐Yes ☐No

PARENT/GUARDIAN: _____

PERSON THAT HAS LEGAL RIGHTS TO CONSENT TO NON-ROUTINE MEDICAL TREATMENT:
(COMPLETE FOR ALL CLIENTS UNDER THE AGE OF 14 AND OBTAIN LEGAL DOCUMENTATION)

_____

REFERRAL SOURCE: _____

REASON FOR REFERRAL:

CURRENT MH TREATMENT: ☐Yes ☐No **TYPE OF SERVICE(S):** _____

REFERRAL SOURCE DISCUSSED SCHOOL BASED SERVICES WITH PARENT/GUARDIAN/CLIENT:
☐Yes ☐No
**Discussed with Client for those 14 and older
DATE: _____ **TIME:** _____

THERAPIST ASSIGNED: _____ **DATE:** _____
REVIEWED BY PROGRAM MANAGER:_____ **DATE:** _____

CREDIBLE ID#: _____