LifeCare
MEDICAL CENTER
caring for generations

Referral for School-Based Mental Health CTSS Services

Date: _____

Name and Agency making Referral:_____

Phone Number: _____ Email:_____

Address: _____ Fax Number: _____

I am referring the following student for School-Based Mental Health Services:

Student Name: _____ Student DOB: _____

Student Address: _____

School Student Attends: _____Grade Level:_____Teacher: _____

Medical Insurance: _____

Primary Policy Holder: _____

Group Number: _____ Policy/ID Number: _____

Parent/Guardian (1) Name: _____Phone: _____

Address: _____ Email: _____

Parent/Guardian (2) Name: _____Phone: _____

Address: _____Email: _____

Who does the child live with? _____

Who has guardianship? _____

Any court or county social service involvement? _____

Are parents aware of this referral? _____

Please list key concerns and/or barriers to service that this student/family is experiencing:

_____

_____

_____

Does this student currently see a mental health therapist? Yes or No
If yes, what is the name of the therapist and agency?

_____

_____

LIFECARE BEHAVIORAL HEALTH
715 Delmore Drive, Roseau, MN 56751 • Phone: 218-463-4732 Fax: 218-463-4778

Has this student had a recent Diagnostic Assessment recommending CTSS? Yes or No
Please check any of the following that apply and send with the referral:

- ☐ Release of Information (ROI)
- ☐ Diagnostic Assessment
- ☐ CASII
- ☐ Statement of Medical Necessity for CTSS Services
- ☐ Individual Treatment Plan
- ☐ If none of these are complete, please check this box
- ☐ IEP or 504 Plan

What Behavioral Concerns do you hope CTSS services will address?

- ☐ Aggression
- ☐ Anger Management
- ☐ Anxiety-Related Behaviors
- ☐ Attention
- ☐ Compulsive Behavior
- ☐ Eating/Food issues
- ☐ Hygiene
- ☐ Hyperactivity
- ☐ Isolation
- ☐ Self-harm/Self-injury
- ☐ Social Skills
- ☐ Tantrums
- ☐ Other/Additional Behavioral Concerns
- ☐ Do Not Anticipate a Need for Skills

Please provide any additional information about the behavioral concerns checked above: (i.e. onset of concerns, frequency of behavior, triggers for behavior, etc.):

_____
_____
_____
_____

Are these behaviors present at Home? Yes or No
Are these behaviors present at School? Yes or No
Interpreter/Translator required? Yes or No
If yes, what language_____

Please mail, email or fax to LifeCare Behavioral Health. Thank you!

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