South Carolina Department of Mental Health

Santee-Wateree Community Mental Health Center
P.O. Box 1946, 215 N. Magnolia Street
Sumter, SC 29151
Telephone: (803) 775-9364
Fax (803) 773-6615

Richard Guess, MSEd, Executive Director
Marian Dehlinger, MD, Medical Director

SCHOOL-BASED REFERRAL FORM for CHILD, ADOLESECENT, & FAMILY SERVICES

SCHOOL ____________________________________ Year ________-__________

Date: ____________________ ***Parent notified of referral?***: ___ Yes ____ No

Student Name: (Last)________________________________(First)__________________(MI)___

Home Address: ____County: _______________

Home Phone: ______________________________Cell Phone: _____________________________

Date of Birth: _________________ Age: ______ Gender: _____ Grade:_____________

Race: _____ Black ___Asian ___Hispanic ___Native American ___White __Other:__________

Parent/Guardian Name(s): ____

If not parent, please indicate guardian's relationship____________________________________

Translator/Interpreter Needed? ___No ___Yes Language: ___________________

Person Referring: __________________________________Title ___________________________

Student Data: (Attach student demographic sheet, grades, discipline record from Power School if available)

At Risk Factors/Presenting Problems
Check all that apply:

- ☐ 504 plan/Behavior Plan
- ☐ Special Education – LD ED TMD PMD EMD
- ☐ Dropping/Failing Grades/ Change in School Performance
- ☐ Family Concerns
- ☐ Attendance/Truancy Concerns
- ☐ Depressed mood/mood swings
- ☐ Habitual Drowsiness/Sleeps in Class
- ☐ Severe worry/anxiety
- ☐ Age Inappropriate behavior/lack of interest in age-level activities
- ☐ Multiple discipline referrals/suspensions
- ☐ Threats to harm self/others
- ☐ Frequent outbursts of anger/temper tantrums
- ☐ Hyperactivity/Fidgeting
- ☐ Poor peer socialization
- ☐ Alcohol/Drug Use
- ☐ Bullies/bullied by others
- ☐ Verbal Abuse/Threats/Fights
- ☐ Recent Trauma/Trauma History
- ☐ Prior Expulsion
- ☐ Health Concerns/Significant weight changes
- ☐ Threats to run away
- ☐ Persistent opposition/aggression toward authority figures
- ☐ Self-injury/destructive behavior
- ☐ Vandalism/Lying/Stealing
- ☐ Alcohol/Drug Use

Health History
(Please circle)

Sleep Disturbance:
Yes No Unknown

Appetite Disturbance:
Yes No Unknown

Alcohol/Drug Use:
Yes No Unknown

Somatic/Physical Complaints:
Yes No Unknown

Are medications administered at school?
Yes No
If yes, please indicate Medications:
If yes, please indicate:______________
____
____
____
____

If yes, please provide name of school nurse:

____
____

Phone:

____

Please indicate the school intervention(s) provided to date, if any, to address the presenting problem **prior to referral** and **the outcome.** Please include referrals to guidance, family contact(s), and/or other outside referrals by name.

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DMH South Carolina Department of Mental Health

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SCHOOL ________________________________ Year ________-__________

Child Name ____ Date of Birth ________________________________

Please provide any **disciplinary actions** including infraction(s) with date, outcome and/or academic barriers exhibited. Please attach corresponding information to include disciplinary action, grades, attendance record, etc., where applicable to expedite processing.

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____

Legal Involvement (circle one): Yes No Unknown

Other Agencies currently involved:

Please mail/fax completed referral to the local Mental Health Center indicated below.

Referral Disposition

For Santee-Wateree Mental Health Use Only:

Date received: ______________________________ Type of Contact: ____ Phone ____ Letter ___ Face to Face

Date(s) Parent Contact: ________________________ ___________________________ ______________________________

Appointment made: Yes ________ No: ________ Declined Services (indicate reason): ______________________________

Summary/Recommendation/Comments:

____

____

Date disposition letter sent to referral source: ________________________________

___________________________ ________________________________

MHP Clinician Date

Form Updated 8/2014

Children, Adolescent & Family Services
P. O. Box 1946
1175 N. Guignard Dr.
Sumter, SC 29151
Ph. (803) 775-7898
Fax (803) 773-5246

Clarendon County Mental Health Clinic
P.O. Box 273
215 Commerce Street
Manning, SC 29102
Ph. (803) 435-2124
Fax: (803) 435-8113

Kershaw County Mental Health Clinic
P.O. Box 845
2611 Liberty Hill Rd
Camden, SC 29020
Ph. (803) 432-5323
Fax: (803) 775-2507

Lee County Mental Health Clinic
P.O. Box 206
817 Brown Street
Bishopville, SC 29010
Ph. (803) 484-9414
Fax: (803) 484-4299