

**North Avondale Montessori**  
**Parent/Guardian Referral for TriHealth Behavioral Health Services**

Date: \_\_\_\_\_ Student Name: \_\_\_\_\_

Grade: \_\_\_\_\_ Classroom/Teacher: \_\_\_\_\_ Past TriHealth services? Y N DK

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian phone #/preferred form of contact: \_\_\_\_\_

**Current Concerns: What brings you to TriHealth services at this time?**

**Past Treatment, Diagnosis, and any Medication:**

**Options for TriHealth Services (Indicate preferences)**

- \_\_\_\_\_ **Individual**
- \_\_\_\_\_ **Group**
- \_\_\_\_\_ **Consultation**
- \_\_\_\_\_ **Classroom Support/Intervention**

**Meetings/Sessions (indicate preference)**

- \_\_\_\_\_ **Telehealth (video/phone)**
- \_\_\_\_\_ **In person**

TriHealth Office Use Only \_\_\_\_\_

Assigned Staff: \_\_\_\_\_

- |  |                                |
|--|--------------------------------|
| _____ Student added to referral list       | _____ Consent received         |
| _____ Intake Scheduled/Completed           | _____ Classroom Observation    |
| _____ Teacher Referral Information Summary | _____ Electronic Chart Created |

