St. Joseph Orphanage - School Referral Form

REVISED 09_2020

Please Return this Form to Your Identified School Staff or SJO School Partner.

Referring For Services

School Name: _____

Services Requested *(Check All That Apply)*

☐ Outpatient (Therapy / Case Management) ☐ Medication Management ☐ Day Treatment (Only Available To School Partners With Day Treatment Services Embedded)

Student's Information

Name: _____ D.O.B: _____ Age: _____ Gender: _____

First Middle Last

Address: _____ City: _____ State: _____ Zip Code: _____

Grade: _____ Social Security Number: _____-_____-_____ Insurance Provider: _____ ID Number: _____

Phone Number: _____ Mobile ☐ Home ☐ Work ☐ Alternative Phone Number: _____ Mobile ☐ Home ☐ Work ☐

Primary Language _____ Secondary Language _____ Is an interpreter needed for services provided in English? Yes ☐ No ☐

Referring School

Person Making Referral: _____ Phone Number: (__ __ __) __ __ __ - __ __ __ __

Guardian Contact Information

Name of the Parent / Guardian Contacted _____ Relationship to the youth? _____ Date of Contact: __ __ / __ __ / __ __ __ __

Method of Contact ☐ Phone ☐ Email ☐ Mail List Phone Number / Email/ etc used: _____

Reason for Referral / Presenting Problem

Check All That Apply:

- ☐ Angry Outbursts
- ☐ Anxiety
- ☐ Bereavement
- ☐ Bullying
- ☐ Defiant Behavior
- ☐ Depression
- ☐ Difficulty of Focus
- ☐ Fighting / Aggression
- ☐ Impulsivities
- ☐ Self Harm
- ☐ Social Skills
- ☐ Suspected Abuse
- ☐ Mood Irritability
- ☐ Other Concerns: _____

Additional Comments:

Additional Questions or Concerns? Our Central Access Department Is Ready To Help!

Fax: (513) 741-0875 **Email:** Admissions@SJOkids.org **Remote Phone:** (513) 334-6584 **Office Phone:** (513) 741-5690 x2214