



The School Board of Brevard County, Florida  
**UNIVERSAL REFERRAL FORM FOR STUDENTS**  
**MENTAL HEALTH / SUBSTANCE USE / CASE MANAGEMENT**



Date: \_\_\_\_\_ School: \_\_\_\_\_

School Counselor/Referral Source: \_\_\_\_\_ Phone number: \_\_\_\_\_ Ext. \_\_\_\_\_

Student's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

Services Requested:  Mental Health Counseling  Substance Abuse Treatment  Case Management

Is student currently receiving counseling/outside services? \_\_\_\_\_

Has parent been contacted regarding issues/concerns of the student? \_\_\_\_\_

Insurance Company & ID Number \_\_\_\_\_

Is a bilingual counselor needed? If so, what additional language: \_\_\_\_\_

Does student have an ESE designation (EBD, SLD, Autistic, OHI, IND)? If so, which one(s): \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Receive texts?  Yes  No

Email address: \_\_\_\_\_

Is student in relative or foster placement?  Yes  No If yes,

Care Manager Name: \_\_\_\_\_ Care Manager phone #: \_\_\_\_\_

**Partner Agency Contact Information (Please check agency receiving referral)**

**Big Bear**  
 (407) 540-9552 fax  
[Referrals@BigBearCounseling.org](mailto:Referrals@BigBearCounseling.org)

**Impower**  
 (321) 639-1194 fax  
[referrals@impowerfl.org](mailto:referrals@impowerfl.org)

**Kinder Consulting**  
 (321) 252-0425 fax  
[Rochelle.bonds@kinderconsulting.com](mailto:Rochelle.bonds@kinderconsulting.com)

**Children's Home Society**  
 (321) 752-3179 fax  
[Marci.cleaver@chsfl.org](mailto:Marci.cleaver@chsfl.org)

**INVO Healthcare**  
 (350) 735-8944 fax

**Lifetime Counseling Center**  
 (321) 632-5796 fax  
[Kyra.marcellino@lccbrevard.org](mailto:Kyra.marcellino@lccbrevard.org)



## Student Referral Feedback Form



Date: \_\_\_\_\_

School: \_\_\_\_\_

Date Referral Received: \_\_\_\_\_

Dates Parent/Guardian Was Contacted: \_\_\_\_\_

**Current Status:**

- Intake set with school-based therapist.  
Intake Date: \_\_\_\_\_ Therapist: \_\_\_\_\_
- Intake set in office per request/due to private insurance restrictions.  
Intake Date: \_\_\_\_\_ Therapist: \_\_\_\_\_
- Unable to provide services due to insurance restrictions. Student referred to the following agency for services: \_\_\_\_\_
- Parent/guardian declined services
- Unable to reach parent/guardian to date.
- Other: \_\_\_\_\_

Additional Information: \_\_\_\_\_

\_\_\_\_\_  
**Agency Representative Signature**

\_\_\_\_\_  
**Date**