The School Board of Brevard County, Florida

UNIVERSAL REFERRAL FORM FOR STUDENTS
MENTAL HEALTH / SUBSTANCE USE / CASE MANAGEMENT

SEDNET
The Multiagency Network for Students with Emotional/Behavioral Disabilities

Date: _____ **School:** _____ **E-Learning:** ☐ **Yes** ☐ **No**

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, ASD, 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

☐ **Impower**
(321) 639-1194 fax
referrals@impowerfl.org

☐ **Kinder Konsulting**
(321) 252-0425 fax
Rochelle.bonds@kinderkonsulting.com

☐ **Children's Home Society**
(321) 752-3179 fax
Marci.cleaver@chsfl.org

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

☐ **Lifetime Counseling Center**
(321) 632-5796 fax
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