CBHSF Referral Form

Referral Date: _____/_____/_____

School Information:

School Name _____

Referral Name _____ Referral Title/School Position _____

Contact Number _____

Student Information:

Name (or preferred name) _____ Date of Birth _____/_____/_____

Gender ☐ M ☐ F ☐ Other _____ Preferred Pronouns _____

Primary Language _____

Address _____

Parent/Guardian/Care Giver Information:

Name_____ Phone Number _____

Primary Language _____ Interpreter Required ☐ Y ☐ N

Health Plan/Insurance (Plan Name, Plan ID#/AHCCCS ID) _____

Presenting Concern:

_____

_____

Attestation of Consent:

☐ I, as a school's staff member, have discussed my concerns with the parent/guardian and verbal permission was given to make this referral.

_____ _____

Staff Signature Date

Send Referral Form To: Email: referrals@rhaz.org or Fax: 602.995.1863

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