



School-Based Universal Referral Form

Referring Agency Information:

Referral Date:

Referring School:

CTDS #:

Referring School Phone Number:

Referring Person Name:

Position:

Referring Person Email:

Client Information:

Client Name:

Client DOB:

Client Phone Number:

Parent/Guardian Name:

Parent/Guardian Phone:

Best Time to Reach:

A.M.

P.M.

Parent/Guardian Email:

Address:

Primary Language (Client):

Primary Language (Guardian):

Referral being made due to substance use: Yes No Unsure

Is the student a:

Danger to Self (DTS)

Danger to Others (DTO)

Not Applicable

If you are in crisis or need immediate assistance, please call 988 or 911.

Reason for referral:

Other agency involvement:

Dept. Child Safety

Div Developmental Disabilities

Juvenile Probation Officer

Other

Consent:

By Checking Box – I, as a school staff member, have discussed my concerns with the Parents/Guardian and have been provided permission to make this referral.

Referring Person Signature:

Date: