**REFERRAL FOR RCSD MOBILE MENTAL HEALTH**

Student Name: Date:

Person Making Referral:

School: Phone:

**Reason(s) for Referral:**

|  |
| --- |
| In-depth assessment for Disruptive behavior (i.e., aggression, threats) |
| In-depth assessment for withdrawal/disengagement behavior (i.e., social isolation) |
| Additional mental health supports following a TIG Crisis |
| Consultation with building level MTSS/SEL/Crisis Team |
| Building level professional development (i.e., Triggers & De-escalation, Trauma)  Describe: |
| Other: |

**Level of Urgency:**

|  |  |  |
| --- | --- | --- |
| Mild (24-48 Hours) | Moderate (24 hours) | Severe (Same day contact) |

Description of challenge(s):

Student’s attitude toward the issue and response to adult interventions:

**Student/Guardian knowledge of the referral:**

|  |  |  |
| --- | --- | --- |
| The student is aware of the referral. | The Parent/Guardian is aware of the referral and in agreement | Date of Parent/Guardian Contact:  Phone: |

* *Please note that the referral will be reviewed by the team, and you will be contacted based on the level of urgency.*
* *Please email this referral form to* [*Mobilementalhealth@rcsdk12.org*](mailto:Mobilementalhealth@rcsdk12.org)
* *Contact Dr. Ruffin or Dr. Tilbe directly to provide additional information*