**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*
* *Contact Dr. Ruffin or Dr. Tilbe directly to provide additional information*