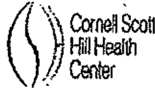
CORNELL SCOTT HILL HEALTH CENTER



Mental Health Referral Form
Child & Family Guidance Clinic
☐428 Columbus Ave ☐226 Dixwell Ave

☐ Substance Abuse ☐ Mental Health ☐SBHC___________
☐Boys & Girls Club ☐TF-CBT ☐ MATCH
☐PMT ☐ CBITS ☐ BOUNCE BACK

Referring Person ______________________________ Date ______________
Agency/Address ______________________________ Tel # ______________

Client Name ______________________ D.O.B. __________ Age ______
Address ______________________ City/Zip Code ______________
Telephone # __________________ H.H.C. # ______________________
SS# ______________________ School ______________ Grade______
Mother __________ Age ______ Father__________ Age ______
Legal Guardian ______________ Relationship to Child __________
Client speaks/understands ☐English ☐Spanish Only ☐Both ☐Other __________
Guardian speaks/understands ☐English ☐Spanish Only ☐Both ☐Other __________
Ethnicity ______________ Sex: ☐Female ☐Male

D.C.F. Involvement: ☐Yes ☐No Legal Mandate: ☐Yes ☐No
D.C.F. Link # __________ If yes, ☐Court ☐Probation ☐Family Relations

Insurance Name: ____________________ Policy # ____________________

Reason for Referral: ____

Any prior involvement with mental health services at the CS-Hill Health Center or elsewhere? ☐Yes ☐No If yes, explain briefly. ______________________________

Is client suicidal or homicidal? ☐Yes ☐No If yes, specify____________________
Any hospitalizations? ☐Yes ☐No If yes, specify (place, date)________________
Any current medications? ☐Yes ☐No If yes, specify name, prescribed by__________

Any drug or alcohol abuse? ☐Yes ☐No If yes, specify____________________
Form completed by: ____________________
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[For Office Use Only]
Emergency ________ Priority __________ Non-Emergency ________
Date Assigned: ________________ Case Assigned To: ________________

Rev. 12-15-17