HEMPFIELD

BEHAVIORAL HEALTH, INC

INNOVATION ■ COMMUNITY ■ EXPERIENCE

Cognitive Behavioral Therapy in School
Referral Form

Date: _____

Referral Source: _____

Referral Phone Number: _____

Referral Email: _____

Name of person referring client: _____

This referral will be followed up with the screening process for inclusion in the CBITS program. Those students that do not qualify for CBITS after screening may be provided a list of programs that could be a better fit for their needs.

Client Information

Name of youth: _____

Youth Date of Birth: _____ Grade: _____

Name of Parent/Guardian/Caregiver: _____

Address: _____

Phone Number: _____

Is the family aware that this referral is being made? ☐ YES ☐ NO

Do we have permission to contact this family and leave a message? ☐ YES ☐ NO

What is the best time to contact Parent/Guardian/Caregiver?

_____

Referral Criteria

This student witnessed or experienced the following traumatic life events:

☐ social isolation

☐ community and/or school violence

☐ accidents and/or injuries

☐ physical abuse and/or domestic violence

☐ natural and/or man-made disasters

Please provide a brief description of concerns regarding this client and the need for services:

_____

_____

_____

_____

Please fax completed forms to *HEMPFIELD BEHAVIORAL HEALTH: 717-221-8006*

2019 North 2nd Street, Harrisburg, PA 17102
717-221-8004 phone ▪ 717-221-8006 fax