HOPE HAVEN PSYCHOLOGICAL RESOURCE

5610 Crawfordsville Road, Suite 200
Indianapolis, Indiana 46224-3739
Phone: (317) 241-HOPE 4673 Fax: (317) 241-0201
www.hopehavenpsych.org

Psychotherapy Referral Form – School Based (HANDWRITTEN)

DATE COMPLETED_____ DATE OF FORWARDED_____ DATE HHPSYCH RECEIVED _____

Please complete all applicable and known portions of this form.

Student's Name **Grade** **Age**

Student's DOB **Student's Social Sec Number**

Student's Identified Gender **Student's Identified Ethnicity**

Referred by or at the suggestion of:

Referrals Contact Info:

Parent's information (name, phone and email)

Please share why you would like this student to receive psychotherapy services? What behaviors, emotions, reactions have you noticed in the classroom? (Please be specific as possible)

Has this student ever engaged in aggressive or self- injurious behaviors or made mention of suicide or homicide? If yes, please share specifics

Please share any experience(s) this student may have had with phy., sexual, emotional abuse, neglect or trauma

What has your relationship/ interactions been like with this student's parents?

Diagnosis, Disabilities or Special Education Services (if applicable)

What are the current behaviors/moods prompting this request for services (check all that apply)?

- ☐ **Anxiety**
- ☐ **Depression**
- ☐ **Mood instability**
- ☐ **Inattention**
- ☐ **Hyperactivity**
- ☐ **Eating disorder symptom**
- ☐ **Poor academic/work performance**
- ☐ **Withdrawal/poor social interaction**
- ☐ **Relationship Concerns**
- ☐ **Unprovoked agitation/aggression**
- ☐ **Self-injurious Behavior**
- ☐ **Behavior problems (e.g., school, home, work)**
- ☐ **Anger**
- ☐ **Bizarre Behavior**
- ☐ **Personality Characteristics**
- ☐ **Substance Abuse**
- ☐ **Psychosis/Hallucinations**
- ☐ **Other:**

Additional Information or Concerns

Have you informed this student's parent that you are making this referral? ■ YES ☐ NO

Have you informed the School Counselor/Special Education Coordinator that you are making this referral? ☐ YES ☐ NO

Once you have completed the form, please inform the School Counselor/Special Education Coordinator and the student's parents, then **FAX** this form to Hope Haven at **(317) 241-0201.** Hope Haven will then contact the student's parents to set up an initial meeting.