DATE: _____

McLean County Center for Human Services
108 West Market Street • Bloomington, IL 61701

MCCHS ID#: _____

OUTREACH/EMBEDDED SCHOOL PILOT PROJECT - REFERRAL FORM

IDENTIFYING INFORMATION

Youth Name: _____ **Sex:** ☐ Male ☐ Female ☐ Other

DOB: _____ **Age:** _____ **Grade:** _____ **School Attending:** _____

Address: _____ _____ IL _____ McLean
Apartment/Street *City* *State* *Zip* *County*

Race: ☐African-American ☐Caucasian/White ☐American Indian/Alaska Native ☐Asian ☐Native Hawaiian/Pacific Islander
☐Other/Multi-Racial: _____ **Ethnicity:** ☐Hispanic/Latino ☐Non-Hispanic/Latino

Medical Coverage: ☐Medicaid ☐Private Insurance ☐Uninsured ☐Unknown

Guardian/Emergency Contact: _____ _____ **Phone:** ( ) -
Name (printed) *Relationship*

REASON FOR REFERRAL (place a check mark in the box next to any characteristics displayed by the individual)

☐Sad or Depressed Emotionally
☐Irritable/Anger/Agitated
☐Sleeping Difficulties/Nightmares
☐Anxiety
☐Inability to Control Self
☐Defiant/Unusual/Disruptive/Oppositional Behavior
☐Attention-Deficit and/or Hyperactivity Issues
☐Substance Abuse: _____
☐Home Difficulties: _____
☐Hearing Voices/Sounds or Seeing Things That Are Not Real
☐Physical/Sexual Abuse
☐Engaged in Risky Behavior
☐Withdrawal/Isolation
☐Poor/Neglected Self-Care
☐Self-Harm
☐Suicidal Ideation
☐DCFS Involvement
☐Other: _____

ADDITIONAL COMMENTS/INFORMATION/RATIONALE FOR REFERRAL

REFERRAL SOURCE

☐ Family/Guardian ☐ Physician ☐ SASS ☐ Truancy Officer ☐ Court/Legal Services
☐ Social Service Agency *(specify)*: _____ ☐ Other: _____
☐ School *(specify district & school)*: _____

Person Completing Form: _____ _____ **Phone:** ( ) -
Name (printed) *Title/Position*

TO BE COMPLETED BY MCCHS STAFF

Student RIN: _____

Screening: _____ Intake: _____
Time and Date *Time, Date, Location*

Attempts:

1	*2*	*3*	*4*	*5*	*6*	*7*	*8*
☐	☐	☐	☐	☐	☐	☐	☐