Benzie-Leelanau
District Health Department
Caring for our Communities

Student Referral Form

Date _____ Referral Source _____ Relationship to student: _____
Name of Student and Student Number _____ Grade _____Age _____ DOB _____
School: ☐ Elementary School ☐ Middle School ☐ High School ☐ Intermediate School
Parent/Guardian _____
Phone _____ Address _____
(Mailing)
Has parent/guardian been notified of this referral? ☐ yes ☐ no Student Notified ☐ yes ☐ no
If yes, by whom and when? _____

Reason(s) for Referral:

Would the student be interested in telehealth sessions, if needed? ☐ yes ☐ no
If yes, does the student have the ability to engage in telehealth sessions at home? ☐ yes ☐ no

CHILD AND ADOLESCENT HEALTH CENTER PROGRAM STAFF USE ONLY

☐ Consent on file
☐ No Consent on file
Date initial packet mailed: _____
Date completed consent form received _____

Outcome
☐ No further action
☐ Scheduled service at CAHC
Provider _____
Date of appointment _____

☐ Received services at CAHC before Provider _____

Follow-up Documentation:

☐ 1st attempt Date _____ Staff initials _____

☐ 2nd attempt Date _____ Staff initials _____

☐ 3rd attempt Date _____ Staff initials _____

☐ Contacted original referring source Date _____

Thank you for your referral!

The Child and Adolescent Health Program is operated by the Benzie-Leelanau District Health Department ,
with major funding from the Michigan Department of Health and Human Services and Michigan Department of Education.