CHILD AND ADOLESCENT HEALTH PROGRAM
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 _______________
____
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☐ 2nd attempt Date ______________ Staff initials _______________
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☐ 3rd attempt Date ______________ Staff initials _______________
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____
☐ Contacted original referring source Date ______________
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Thank you for your referral!

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