Codman Square
Health Center

Codman Square Health Center - Mobile Health Unit
637 Washington Street Dorchester, MA 02124 • 617 825 9660
codman.org/mobilehealth • CSHCMobileUnit@codman.org

BEHAVIORAL HEALTH SERVICES REFERRAL FORM

Name: _____

Date of Birth: _____ Date of Referral: _____

Parent/Guardian *(please specify)*: _____ Phone: _____

Health Insurance *(name and policy number)*: _____

Parent/Guardian Consent: ☐ Yes ☐ No Date of Consent: _____

(Parent/Guardian consent required for students under 18)

Referred by: _____

Preferred language: _____

Prior counseling history: _____

_____

_____

Reason(s) for referral or problems/concerns related to *(check all that apply)*:

☐ Depression/Anxiety	☐ Conduct issues	☐ Substance abuse
☐ Social skills	☐ Peer/Relationships	☐ Risk of school failure
☐ Loss and grief	☐ Witness to, or victim of, violence	☐ LGBTQ/Gender Identity
☐ Family concerns	☐ Bullying	☐ Other

Additional information about referral reason and history: _____

_____

_____

Prior interventions to address referral concerns: _____

_____

_____

Availability of for counseling: _____

Assigned to: _____ Date of first contact:_____