Egyptian Health Department
Project AWARE
Referral Form

Child Name: ______________________________ Parent/Guardian Name: ______________________

Date: __________ Referral Source: ____________________ Referral Contact phone: ____________________

Address: ____

Phone: (Home) ________________________________ (Work) _________________________________

Date of Birth: __________________ Grade: ________ Sex: ______________ Medicaid: Y/N/Unsure

Services Requested: ____

Summarize reason for referral:

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Eligibility Factors- Please check all eligibility factors that apply:

___ Child has IEP
___ Academic Difficulty Current GPA: ______
___ School Move
___ History of truancy: # last year___ # current year___
___ History of suspensions: # last year___ # current year___
___ History of expulsions: # ___ date _____
___ Child at risk of removal from home, school, or community
___ At risk of school action (suspension, expulsion, truancy) # of office discipline referrals___
___ Multi-agency involvement in need of collaboration
___ Known Mental Health Issues of Child
___ Suspected Mental Health Issues of Child
___ Child Under Stress
___ Basic Needs Unmet
___ Child Behavior
___ Child Depression
___ Child Medical Needs
___ Child Neglect
___ Child Physical Abuse
___ Child Sexual Abuse
___ Child Substance Abuse
___ Mental Health Issues of Parent
___ Parent-Child Conflict
___ Parental Conflict
___ Parent Death
___ Parent Illness
___ Parent Separation
___ Parent Substance Abuse
___ Placed Out of Home
___ Sexual Acting Out
___ Domestic Violence
___ Inadequate Social Skills
___ Juvenile Del./Court
___ Special Needs Child/Parent
___ Unstable Housing
___ Financial Issues

Please submit a copy of this to the Project AWARE team member at your school

Project Aware Use Only:

Date Referral Received: ______________________
Existing Client: Y/N
Date of CANS: ______________________
Tier of Service: ______________________
Date Referral Source Contacted: ______________
Dates of most recent services: ________
CANS scores: Needs______ Strengths__________
Date of Referral for other services: ____________