CBI
COMMUNITY BRIDGES, INC.
CELEBRATE BELIEVE INSPIRE

Referral Form

Person Making Referral: _____ Contact Info: _____

Relationship to Patient: _____ School: _____ Grade:_____ Date: _____

Check ALL that apply:

☐ Patient is seeking virtual therapy
☐ Patient is seeking in-person therapy
☐ Patient is seeking Substance Use Treatment
☐ Guardian has approved of CBI staff to contact guardian and set up intake

Student Information:

Patient's Name: _____ DOB: _____

Guardian's Name: _____ Preferred Language: _____

Guardian's Phone#: _____ Patient's Phone#: _____

Guardian's Email:_____ Patient's Email:_____

Ethnicity: _____ Gender (how does student identify?): _____

Current living situation (ie. living with parent/guardian, foster home, group home, etc.): _____

Address: _____ City: _____ Zip: _____

Referral Information:

Reason for Referral (please give examples of statements, observations, or behaviors that led you to make this referral): _____

_____

_____

Does the patient display behavior that severely or significantly impacts their functioning at school?

☐ Y or ☐ N ; If yes, please describe _____

_____

Has patient expressed thoughts of or attempted suicide, self-harm, or harm to others? ☐ Y or ☐ N ;

If yes, please describe _____

_____

Is there current use of substances? ☐ Y or ☐ N ; If yes, what substances? List all _____

_____ Last use? _____

Does patient have a mental health diagnosis? ☐ Y or ☐ N ; if yes, student's diagnosis:

_____

Is patient currently on any psych medications? _____

Is the patient currently involved with a psych provider, children's agency, or another counseling agency?

☐ Y or ☐ N ; If yes,

Name: _____ Email: _____ Phone: _____

Is the patient involved with juvenile probation? ☐ Y or ☐ N ; If yes,

Name: _____ Email: _____ Phone: _____

Is the patient involved with DCS? ☐ Y or ☐ N ; If yes,

Name: _____ Email: _____ Phone: _____

Insurance Name (AHCCCS, BCBS, Cigna, etc. or "None Currently"): _____

If student is on AHCCCS, AHCCCS ID #: _____

Guardian Consent:

☐ I, as the parent/guardian of this child, give my consent to make this referral

☐ I, as the school staff member, have discussed my concerns with the parent/guardian, and received verbal permission to make this counseling referral

Signatures:

☐ Parent/Guardian; _____

☐ School Staff Member; _____

Please send all referrals to AMATReferrals@cbridges.com

Subject reading: AMAT Referral