HEALTH DEPARTMENT of Northwest Michigan
1-800-432-4121

# 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 _____
_____
_____
☐ 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 Health Department of Northwest Michigan,
with major funding from the Michigan Department of Health and Human Services and Michigan Department of Education.