



Office Use

Date Received: _____

Provider: _____

Referral for Services

Referred Student's Name: _____ Date of Referral: _____

Date of Birth: _____ Student Phone: _____

Address: _____

School: _____ Is the student aware of this referral? Yes No

Other Community or School Services the Client is Receiving:

- ☐ JPO ☐ Citation Program ☐ Counseling ☐ School Social Work- IEP
☐ School Psych-IEP ☐ Other IEP Services ☐ Other _____

Parent/Guardian Name: _____ Parent/Guardian Phone: _____

Parent/Guardian Email: _____

Is the parent/guardian aware of this referral? (Circle one) Yes No

Please tell us a little bit about the concerns you have about this student. (Check all that apply and give a short explanation.)

- ☐ Emotions
☐ Behaviors
☐ Substance Use
☐ Family Problems
☐ Problems at School

Explanation:

How soon does the student need to be seen?

- ☐ 24- 48 Hours** ☐ 1 - 2 Weeks ☐ One Month

Referred by: _____ Phone Number: _____

Relationship to student: _____

****We cannot guarantee that the student will be seen in the requested time period. If you have an immediate concern or fear for the safety of the student, please call us (575-630-7974) in addition to sending the referral form.****

Please fax this form to 575-258-3320 or email to ashlee@r9sbhc.org

Region 9 School Based Health Center

2002 Sudderth Drive, Ruidoso, NM 88345

Phone: 575-630-7974 Fax: 575-258-3320

Parents or Students 14 years +: Complete this portion of the form if you would like the provider to be able to talk with school personnel about care received at the R9 SBHC.

Release of Protected Health Information

I hereby authorize the Region 9 School Based Health Center to release information pertaining to my care to:

Name(s): _____

Organization/School: _____

Address: _____

Phone Number: _____

Type of Information:

I authorize that the record/information to be released will include health information relating to (check if applicable):

☐ HIV/AIDS infection

☐ Drug/Alcohol abuse

☐ Mental Health

PROHIBITION OF REDISCLOSURE: Federal Law (42 CFR Part 2) and state laws (NMSA 1978 Section 24-1-9.5 (1996); NMSA 1978 Section 32A-6-15 (1995); NMSA 1978 Section 24-2A-6 (1997)) prohibit further disclosure of HIV/AIDS and other sexually transmitted diseases, and mental health and alcohol abuse and drug abuse information to any person without securing another proper written authorization for that purpose, or as otherwise permitted by Federal regulations or state law.

Patient Name

Date

Signature of Patient or Legal Representative

Printed Name of Patient's Representative (if applicable)

Relationship to Patient (if applicable)

Parent or guardian of unemancipated minor

Court appointed guardian

Executor or administrator of decedent's estate

Power of Attorney