RFS BEHAVIORAL HEALTH

T.A.C.K.L.E. Program

Referral Form

Please include as much information as possible

Client Name _____ D.O.B. _____

Address _____

City _____ Zip Code _____

Parent/Guardian _____ Phone _____

If Adult check services requested MH ☐ AOD ☐

(Skip to referral source)

School _____ Teacher _____ Rm# _____

Referral Source (Principal, teacher, parent, etc.) _____

Person making referral _____ Date _____

Reason for referral _____

_____

_____

_____

_____

_____

_____

If possible please attach client's school schedule.

Office use only Follow up:

Date contacted: _____ Result: _____

Date contacted: _____ Result: _____

Date contacted: _____ Result: _____

Date of Assessment _____ Clinician: _____