NURSE CASE MANAGEMENT
REFERRAL FORM

Referral Date

Student Name | ◯ Male ◯ Female Gender | Grade | Date of Birth

Parent Last Name | Parent First Name | Parent Email

Address | City | State | Zipcode

Parent Home Phone | Parent Cell Phone | Parent Work Phone

Teacher/Counselor/Advisor

AREAS OF CONCERNS (please check all that apply)

Referral Criteria (check one of the top 3 choices)

- ☐ Acute/chronic and/or life-threatening health condition
- ☐ Unmet health care need (Physical/Behavioral/Mental)
- ☐ Absenteeism
- ☐ Other (below)

Co-Morbid Factors (check all that apply)

- ☐ Chronic illness (Physical/Mental)
- ☐ Drug/alcohol Issues
- ☐ English Language Learner
- ☐ High Mobility
- ☐ Homeless
- ☐ Poverty/low income
- ☐ School re-entry
- ☐ Special Education
- ☐ Discipline referral

Risk Criteria (check one

- ☐ Increased morbidity/mortality
- ☐ Decreased school engagement including high absenteeism
- ☐ unidentified or unmet health need

Please note any additional concerns or pertinent information including known diagnosis:

Referral Verification

Print Name | Signature