420 East Sarnia Street, Suite 2100
Winona, MN 55987

info@hvmhc.org
www.hvmhc.org

School Linked/Based Mental Health Services
Referral Form

Date ________________ Services Requested by: ____________________________Phone:__________________________________

Student (Client) Name: __________________________ Home Address: ____

Date of Birth: ____________________Grade: _______ School:____

Is the student currently on IEP: Yes____ No ____ If yes, does the IEP recommend mental health related services: Yes ____ No ____

Insurance or Other Payment Source: ____ Medical Assistance#:__________________

Please list any services or therapists student is currently involved with:

____

Please list any services or therapists student was previously involved with:

____

Household Composition:
CHILDREN:

Full Name	Relationship to Child	Full Name	Relationship to Child
______________________	___________________	______________________	___________________
______________________	___________________	______________________	___________________

ADULTS:

Full Name	Relationship to Child	Full Name	Relationship to Client
______________________	___________________	______________________	___________________
______________________	___________________	______________________	___________________

Preferred way to be contacted by Hiawatha Valley Mental Health Center staff:

Phone: ____ Email: _____________________________________

Best time to be reached: ___________________ Can a message be left on phone number provided: YES □ NO □

Cultural Needs: Preferred Language: ____________________________Interpreter Needs:___________________________________

Cultural Provider Requests/Needs:____

Service Preferences: ____

Safety: Crisis situation: NO □ YES □
Explain:____

Please list any history of suicide or harm to self or others for any family member(s): ____

____

____

Reason for referral (explain concerns or problems include any diagnoses/medications): ______________________________________

____

____

What are your expectations/goals?

____

____

PLEASE HAVE THE LEGAL GUARDIAN READ AND SIGN BELOW:

I AUTHORIZE AND CONSENT THAT THE SCHOOL LINKED MENTAL HEALTH PROVIDER FROM HIAWATHA VALLEY MENTAL HEALTH CENTER MEET WITH MY CHILD AT MY CHILD'S SCHOOL FOR INDIVIDUAL AND/OR GROUP THERAPY OR SKILLS TRAINING.

I AUTHORIZE THE RELEASE TO THE MINNESOTA DEPARTMENT OF HUMAN SERVICE AND HIAWATHA VALLEY MENTAL HEALTH CENTER ALL INFORMATION NECESSARY TO ACCOMPLISH THE REFERRAL FOR SERVICES AND TO RECEIVE GRANT FUNDING FROM THE MINNESOTA DEPARTMENT OF HUMAN SERVICES.

I AUTHORIZE FOR THE REFERRAL SOURCE AND HVMHC STAFF TO COMMUNICATE WITH EACH OTHER REGARDING THE STATUS OF THIS REFERRAL ONLY.

____

SIGNATURE OF PARENT OR GUARDIAN PRINTED NAME DATE

Please submit completed referral form to:
Youthreferrals@hvmhc.org
Hiawatha Valley Mental Health Center
420 East Sarnia Street, Suite 2100
Winona, MN 55987
Phone: 507-474-9320
Fax: 507-474-9471