ALACHUA COUNTY PUBLIC SCHOOLS

Referral Form

MERIDIAN BEHAVIORAL HEALTHCARE, INC.

Children's Outpatient Counseling Services

Fax to: 352-373-4817 ATTN: Children's Outpatient Program Manager

Student Name:

Date of Birth:

Date of Referral:

Referred by:

Contact Information:

School Attending:

Current Grade:

Teacher:

REASON FOR REFERRAL:

Parent /Guardian Name:

Home Address:

Telephone #1: Telephone #2:

Okay to Leave Message: Yes

Other information:

FOR MERIDIAN FOLLOW-UP:

Date Received:_____ Assigned to:_____ Outcome:_____

Caretaker contacted on:_____ Intake Appointment:_____

Comments: