Student Services Referral Form

Date: _____ School: _____

Type of Referral

_____ Mental Health Crisis or Acute Hospitalization Follow-up

_____ School Based Counseling Services for General Concerns

Agency Information

Agency Name: _____

Agency Phone Number: _____

Student Information

Name: _____

Date of Birth: _____Grade:_____

Parent/Guardian:_____Phone:_____

Address:_____

City:_____State:_____Zip:_____

Area(s) of concern (Check all that apply):

_____ Anger or aggression

_____ Anxiety

_____ Depression

_____ Difficulty or refusal to do school work

_____ Difficulty with attention/focus/ distractibility

_____ Excessive tardiness or absences

_____ Family unit disruption

_____ Irritability toward peers

_____ Irritability toward teachers/adults

_____ Reports of family issues impacting school

_____ Self-injurious behaviors/ideations

_____ Suspected substance use

_____ Withdrawn from activities (Isolating self)

_____ Other: _____

Please provide any other important input from home, school, and/or community:

_____

_____

_____

_____

_____

Full Legal Name of Student: _____
Student DOB: _____

Consent to Release/Exchange Information

I authorize and consent for Vigo County School Corporation and its employees to release and/or exchange information with _____ (provider/office) in regards to the treatment and care of your student,_____. I understand that educational, medical, substance abuse, mental health, and records of confidential communications may be contained in the information being shared. I understand this authorization is voluntary. The purpose of such disclosure is to facilitate a referral and coordinate school-based counseling services for your student at school.

This consent, unless revoked earlier in writing, expires _____. This consent will last no longer than one calendar year.

I understand my rights and hereby authorize the use or disclosure of my individually identifiable health/educational information as set forth herein. The purpose of this release has been verbally explained to me and I was given an opportunity to ask questions.

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

For Agency to Complete:
Please indicate the outcome of the crisis assessment and return this form to the referring school counselor:

_____ Return to school with safety plan (please attach safety plan)
_____ Return to school without safety plan
_____ Referred to outpatient therapy (Agency: _____)
_____ Referred to hospital for acute stabilization (Hospital Name: _____)
_____ Student and parent did not show for crisis assessment.
_____ Other: _____

Parent/Guardian Signature: _____ Date: _____

Agency Representative Signature: _____ Date: _____

VIGO COUNTY SCHOOL CORPORATION

Full Legal Name of Student: _____
Student DOB: _____

COLUMBIA-SUICIDE SEVERITY RATING SCALE

General Screen with Triage Points

SUICIDE IDEATION DEFINITIONS AND PROMPTS	PAST MONTH	
Ask questions that are in bold and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
(1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
(2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, *"I've thought about killing myself" without general thoughts of ways to kill oneself/ associated methods, intent, or plan."* ***Have you had any actual thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
(3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place, or method details worked out. *"I thought about taking an overdose, but I never made a specific plan as to when, where, or how I would actually do it…and I would never go through with it."* ***Have you been thinking about how you might do this?***		
(4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to *"I have the thoughts, but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?***		
(5) Suicidal Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
(6) Suicide Behavior Question: ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof, but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***Was this within the past 3 months?***	**LIFETIME**	
	PAST 3 MONTHS	

RESPONSE PROTOCOL TO C-SSRS SCREENING
Item 1 – Behavioral Health Referral & Safety Plan
Item 2 – Behavioral Health Referral & Safety Plan
Item 3 – Behavioral Health Referral, Safety Plan & Referral for crisis assessment
Item 4 – Safety Plan & Referral for crisis assessment
Item 5 – Safety Plan & Referral for crisis assessment
Item 6 – Behavioral Health Referral, Safety Plan & Referral for crisis assessment
Item 6 – 3 months ago or less: Safety Plan & Referral for crisis assessment

VIGO COUNTY SCHOOL CORPORATION

Full Legal Name of Student: _____
Student DOB: _____

CRISIS ASSESSMENT LOCATIONS

Hamilton Center Access Center 620 8th Avenue Terre Haute, IN 47804 (800) 742-0787 (812) 231-8208 (fax) http://www.hamiltoncenter.org	**Harsha Behavioral Center** 1980 Woodsmall Road Terre Haute, IN 47802 (866) 644-8880 http://harshacenter.com
Regional Hospital Emergency Department 3901 South 7th Street Terre Haute, IN 47802 (812) 232-0021 http://regionalhospital.com	**Union Hospital Emergency Department** 1606 North 7th Street Terre Haute, IN 47804 (812) 238-7000 http://myunionhealth.org