

# **Student Services Referral Form**

Date:		School:
Type of Referral		
Mental Health Crisis or Acute H	ospitalization	Follow-up
School Based Counseling Service	es for General	l Concerns
Agency Information		
Agency Name:		
Agency Phone Number:		
<b>Student Information</b>		
Name:		
		Grade:
Parent/Guardian:		Phone:
Address:		
City:	State:	Zip:
Area(s) of concern (Check all th	at apply):	
Anger or aggression		Irritability toward peers
Anxiety		Irritability toward teachers/adults
Depression		Reports of family issues impacting school
Difficulty or refusal to do school	l work	Self-injurious behaviors/ideations
Difficulty with attention/focus/		Suspected substance use
distractibility		Withdrawn from activities (Isolating self)
Excessive tardiness or absences		Other:
Family unit disruption		
Please provide any other important input	from home, s	school, and/or community:



Full Legal Name of Student:
Student DOB:

# Consent to Release/Exchange Information

I authorize and consent for Vigo County School C	Corporation and its employees to release and/or exchange
information with	(provider/office) in regards to the treatment and care of
	I understand that educational, medical, substance abuse,
	cations may be contained in the information being shared. I
	purpose of such disclosure is to facilitate a referral and
coordinate school-based counseling services for your	
coordinate school-based counseling services for your	student at school.
This consent, unless revoked earlier in writing, expir	res 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.	
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Parent/Guardian Signature:	Date:
Witness Signature:	Date:
For Agency to Complete:	and rature this form to the referring school counselor
riease indicate the outcome of the crisis assessment a	and return this form to the referring school counselor:
Return to school with safety plan (please attac	:h safety plan)
Return to school without safety plan	
Referred to outpatient therapy (Agency:	
Referred to hospital for acute stabilization (He	-
Student and parent did not show for crisis ass	
Other:	
Parent/Guardian Signature:	Date:
Agency Representative Signature:	Date



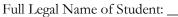
Full Legal Name of Student:	
Student DOB:	

# **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.		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 itand 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?			
<b>(5) Suicidal Intent with Specific Plan:</b> 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:		IME	
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		ONTHS	
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?			

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	





Student DOB:

# **CRISIS ASSESSMENT LOCATIONS**

#### **Hamilton Center Access Center**

620 8<sup>th</sup> 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 7<sup>th</sup> Street Terre Haute, IN 47802 (812) 232-0021 http://regionalhospital.com

### Union Hospital Emergency Department

1606 North 7<sup>th</sup> Street Terre Haute, IN 47804 (812) 238-7000 http://myunionhealth.org