Teen Health Center, Inc.
P.O. Box 925, Galveston, TX 77553
Mental Health Team Phone: 409.766-5713 FAX: 409.765.5026 WEBSITE: www.teenhealthcenter.org

REFERRAL SOURCE

Date: _____ **Name of Referring Person:** _____

Relationship to Student: _____ **Phone:** _____

If not the parent, I have contacted the parent/guardian and discussed the situation concerning the student below: YES or NO
(OR)
I am the parent/guardian of the student/patient below: YES or NO

STUDENT INFORMATION

Student's Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Date of Birth: _____ **Sex Assigned at Birth:** ☐ **Male** ☐ **Female** **Gender Identity (optional):** _____

Hispanic/Latino: ☐ **Yes** ☐ **No**

Race: ☐ **White** ☐ **Black** ☐ **Asian** ☐ **Native American** ☐ **Pacific Islander** ☐ **Biracial** ☐ **Other**

School: _____ **Grade:** _____ **Student Cell Phone:** _____

Student Address: _____
Street **City** **State** **Zip**

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name: _____ **Email:** _____

Primary Phone: _____ **Secondary Phone:** _____

Primary Language Spoken in Home: ☐ **English** ☐ **Spanish** ☐ **Other(Specify)** _____

REASON FOR REFERRAL

Please describe the nature of the problem, or the reason you are seeking care for this individual.

_____

_____

_____

_____

If you think this individual is in danger of hurting themselves or others please call 911, go to the nearest Emergency Room, Call Gulf Coast Center Crisis Hotline 1-866-729-3848, and/or Call the National Suicide Prevention Hotline at 1-800-273-8255. CONFIDENTIAL: This communication contains confidential information. If you receive this in error, please destroy immediately. Revised 08/16/2021

FOR INTERNAL USE ONLY
Handled by:_____
Assigned to:_____
☐ THERAPY ☐ PSY ☐ BP
DATA: _____ _____
☐ **Crisis Information given to Referral Source.**