CHRIS180 Changing Directions. Changing Lives.

DBHDD Georgia Department of Behavioral Health & Developmental Disabilities

School-Based Therapy Interest Form

Date: ________

Student Information

Student's Name: ________ Age: ____ Grade: ____

Your Name: ________ Phone Number: ____ - ____ - ____

Relationship to Student: ☐ Parent/Guardian ☐ Grandparent/Great Grandparent ☐ Other: ________

School Information

School Name: ________ Grade: ____ Homeroom Teacher: ________

Reasons for Referral (Check All That Apply)

- ☐ **Academic Performance**
- ☐ **Behavior (outside of school)**
- ☐ **Family/Community Related Concern**
- ☐ **Self-Harm** Current History
- ☐ **Suicidal Thoughts and/or Plans** Current History
- ☐ **Drug and Alcohol Use**
- ☐ **Health and Wellness Concerns** (Please Explain In "Additional Comments" Section)
- ☐ **Classroom Conduct**
- ☐ **Trauma**
- ☐ **Depression**
- ☐ **Anxiety**
- ☐ **Grief/Loss**
- ☐ **Peer Conflict**
- ☐ **Other** (Please Indicate): ________

Additional Comments about Student Behavior or Symptoms

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