HEARD Alliance

ATTACHMENT 2.9

REFERRAL, CONSENT & FOLLOW-UP FORM

HEALTH SERVICES AND SPECIAL EDUCATION

Referring Staff:_____ EMAIL:_____ Referral Date:_____

Signature (required):_____ PHONE: _____ Fax Number: _____

I. GENERAL INFORMATION

Student: _____ DOB_____ Age: _____

Address: _____ Phone: _____ Sex: M or F

School: _____ Grade: _____ Primary Language: _____

II. PLEASE PROVIDE THE FOLLOWING CONFIDENTIAL INFORMATION FOR THE STUDENT NOTED ABOVE:

- ☐ **PSYCHOLOGICAL**
- ☐ **MEDICAL**
- ☐ **HEALTH AND DEVELOPMENT**
- ☐ **EDUCATIONAL**
- ☐ **OTHER:**
- ☐ **PSYCHIATRIC HISTORY**
- ☐ **LEGAL STATUS**
- ☐ **DIAGNOSIS**

III. TO BE COMPLETED BY PARENT/GUARDIAN: I CONSENT TO COMMUNICATION AND EXCHANGE OF INFORMATION BETWEEN

DR. _____ PHONE # _____

AND District STAFF TO DISCUSS AND SHARE RECORDS & CONDITIONS PERTAINING TO THE ABOVE. THIS INFORMATION IS CONFIDENTIAL AND MAY NOT BE GIVEN TO EMPLOYEES OF OTHER SCHOOLS, PUBLIC AGENCIES, OR INDIVIDUAL PROFESSIONALS IN PRIVATE PRACTICE WITHOUT MY CONSENT.

Parent/Guardian (Student Over 18) Name _____ Date _____

Parent/Guardian (Student Over 18) Signature _____

This authorization shall be valid until _____ (date). You may provide a date after which no information can be released.

If no date is provided, authorization is valid for one year from date of signature. This consent is voluntary.

To revoke this consent, send a copy to the referring person above at _____

☐ I revoke this consent for communication and exchange of information.

I understand that the recipient may not lawfully further use or release the information unless another authorization is obtained from me or unless such use or release is specifically required or permitted by law. In accordance HIPPA, FERPA and applicable California laws, all personal and health information is private and must be protected.

☐ Copy provided to Parent / Guardian

IV. TO BE COMPLETED BY HEALTH CARE PROVIDER OR BEHAVIORAL HEALTH PROVIDER

Diagnosis:_____ Treatment: _____

Medication(s): _____

Additional referral: _____ Reason: _____

School staff will contact provider if needed for clarification/recommendations. The information being requested is often personal in nature; therefore person-to-person communication may be best in some cases.

Provider Signature:_____ Print Name: _____

Fax #: _____ Phone #: _____

PLEASE RETURN TO THE REFERRING STAFF MEMBER, INDICATED AT THE TOP OF THIS PAGE