Three Rivers Health
PAWS Community Adolescent Health Center and E3 Program

REFERRAL FORM

Three Rivers Health PAWS Community Adolescent Health Center (CAHC) and E3 Program, in cooperation with Three Rivers Community Schools, may provide students a variety of primary care and mental health services. These include comprehensive physical exams and immunizations, management of both chronic and acute illnesses and injuries, mental/behavioral health screening, and management of mental health concerns through interventions that include evidence-based therapy and counseling. With proper consent, students may access services during the school day.

INSTRUCTIONS:
Please complete the form below and fax it to the PAWS Community Adolescent Health Center or email to klucas@trschools.org. The parent/guardian will be notified of this referral and PAWS CAHC staff will discuss available service options.

Student: _____ **Date of Birth:** _____

Area of Concern: **[ ] Behavioral** **[ ] Social / Emotional** **[ ] Primary Care**

Behavioral / Social / Emotional Concerns: **(Please check all that apply)**

[ ] Talks excessively
[ ] Inattentive, distractible/forgetful
[ ] Fights and is aggressive
[ ] Gets out of seat and moves constantly
[ ] Disorganized, makes careless mistakes
[ ] Argumentative and defiant
[ ] Interrupts/blurts out responses
[ ] Angry towards others

[ ] Anxious and fearful
[ ] Restless on edge
[ ] Clingy behavior
[ ] Worries Excessively
[ ] Specific fears or phobias
[ ] Appears distracted
[ ] Difficulty sleeping
[ ] Difficulty concentrating
[ ] Self Injury

[ ] Sad, depressed or irritable mood
[ ] negative self-statements
[ ] Hopelessness
[ ] diminished interest in activities
[ ] Low self esteem
[ ] Low or decreased motivation

Are you aware of or do you suspect any of the following:

[ ] Physical Abuse
[ ] Bullying
[ ] Foster Care
[ ] Sexual Abuse
[ ] Community Violence
[ ] Parental Alcohol/Substance Use
[ ] Emotional Abuse
[ ] Parental Separation/Divorce
[ ] Domestic Violence
[ ] Parental Incarceration
[ ] Neglect

Primary Care: **(Please check all that apply)**

[ ] Well Care Exam / Sport Physical [ ] Injury/Illness [ ] Immunizations [ ] Vision issues [ ] Dental Issues

[ ] Other: _____

_____

Person Making Referral: _____ Date: _____

Fax Referral Form to PAWS/CAHC at 269-273-3347 or email to klucas@trschools.org

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