GLADE RUN
LUTHERAN SERVICES
Inspiring Hope. Transforming Lives.

Mental Health Partnership Referral Form – School:_____ **Date of Referral:** _____

ALL SECTIONS MUST BE COMPLETED FOR REFERRAL TO BE PROCESSED.

WE ARE UNABLE TO PROCESS INCOMPLETE REFERRALS.

Name:_____ DOB: _____

SSN: _____ Grade: _____

Age: _____ Race: _____ Gender: _____

Address: _____City_____Zip Code_____

Parent/Guardian: _____ Relationship to Client: _____

Phone Number(s): _____

Areas of Concern:	Yes	No
1. Aggression (physical and/or verbal)	☐	☐
2. Impulsive/Makes poor choices	☐	☐
3. Mood Problems (Withdrawn/Anxiety)	☐	☐
4. Self-damaging acts	☐	☐
5. Do you believe this child is at risk of harming self or others?	☐	☐
Are these behaviors occurring in the home?	☐	☐

Please Circle what service you are interested in:

Group Therapy Individual Therapy Both

Additional Concerns: _____

Insurance: _____STATE MA ID (10 Digits): _____

Private Insurance: _____ID #: _____ Group #: _____

Policy Holder: _____ Relationship to client: _____

Policy Holder DOB: _____ Policy Holder Employer: _____

Guardian Signature _____ Date _____

Student Signature _____ Date _____

Fax referral form to:
Referral Coordinator at 412-661-1867
For Questions, please contact Glade Run Building Supervisor