

SCHOOL REFERRAL FORM



Phone: (864) 406-6041

Fax: (864) 406-6042

Website: gatewaychildrens.com

MEDICAID ACCEPTED!

Email To: referrals@gatewaychildrens.com | Fax To: (864) 406-6042

✓ Referring School: _____ Fax: (_____) _____ - _____

✓ Contact Name: _____ Phone: _____ Email: _____

4 REFERRAL LOCATIONS (SELECT ONE): Greenville Mauldin Anderson Spartanburg

Date: _____ Student's Name: _____ Age: _____ DOB: _____

Address: _____ City: _____ Zip Code: _____

Telephone: Home: _____ Mobile: _____ Gender: Male Female

Parent/Guardian who was notified of referral: _____

Medicaid Plans & Self-Pay Accepted Only

Medicaid Plans Accepted: Medicaid First Choice Molina Blue Choice Absolute Total Care Wellcare

Self-Pay – we will contact parent(s) to discuss payment arrangements.

Non-English speaking -- ****Client's responsibility to provide own interpreter for services to be rendered.**

**** Please Notify Parent/Guardian of This Referral, Thank You! ****

This referral is for: Counseling/Therapy
 Professional Consultation

Please assess and treat for the following problems or conditions (check all that apply):

- | | | |
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| <input type="checkbox"/> Absences/Late/Truancy | <input type="checkbox"/> Disrespectful/Defiant | <input type="checkbox"/> Physical Abuse Exposure |
| <input type="checkbox"/> Academic Decline/Failure | <input type="checkbox"/> Disruptive behavior | <input type="checkbox"/> Self-Esteem Problems |
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Drug use | <input type="checkbox"/> Self-Harm or Self-Mutilation |
| <input type="checkbox"/> Aggression/Anger | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Separation Anxiety |
| <input type="checkbox"/> Anxiety/Panic Attacks | <input type="checkbox"/> Emotional/Moodiness | <input type="checkbox"/> Sexual Abuse Exposure |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Family Problems | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Bullying | <input type="checkbox"/> Flirting Inappropriately | <input type="checkbox"/> Social Problems |
| <input type="checkbox"/> Coping Skills - Poor | <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Stubborn |
| <input type="checkbox"/> Complains excessively | <input type="checkbox"/> Inappropriate Talking/Verbalization | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Conduct issues | <input type="checkbox"/> Inattention/Poor attention | <input type="checkbox"/> Violence/Fighting |
| <input type="checkbox"/> Depressed/Sad often | <input type="checkbox"/> Shy/Non-participation | <input type="checkbox"/> Other: _____ |