Healthy School Program Referral

Thank you for submitting a referral on behalf of your student to IEHP's Health Navigator Team. Please complete all areas to the best of your knowledge. Feel free to leave areas blank if the response is unknown. Once complete, please send the referral to healthnavigators@iehp.org.

Name of student:

DOB:

Student's preferred name:

Student's pronouns:

Does the student have health insurance? **Yes** ☐ **No** ☐

Is the student an IEHP member? **Yes** ☐ **No** ☐

What is their IEHP ID?

Date of Referral:

Referring school:

Referring school district:

Referring school staff and title:

Contact phone number and email address of referring staff:

Parent/caregiver name and phone number:

If known, the best time to call the parent/caregiver:

Primary language of the parent/caregiver:

Is the parent/caregiver aware of the referral to the Healthy School program? **Yes** ☐ **No** ☐

If no, please explain:

Is the student pregnant or a parent? **Yes** ☐ **No** ☐

I. Reason(s) for the referral (check all that apply):

Homelessness/risk of homelessness: **Yes** ☐ **No** ☐

Food insecurities: **Yes** ☐ **No** ☐

Transportation needs: **Yes** ☐ **No** ☐

Financial hardships: **Yes** ☐ **No** ☐

Assistance required to help the student/family apply for insurance coverage: **Yes** ☐ **No** ☐

Chronic absenteeism: **Yes** ☐ **No** ☐

Is this referral related to SART/SARB concerns: **Yes** ☐ **No** ☐

Concerns related to accessing care with medical providers/PCPs/specialists: **Yes** ☐ **No** ☐

Concerns related to accessing care with behavioral health providers: **Yes** ☐ **No** ☐

Concerns related to accessing care with substance use providers/programs: **Yes** ☐ **No** ☐

Concerns related to gaps with immunizations, vaccines or health check-ups: **Yes** ☐ **No** ☐

Assistance with navigating health plan benefits (vision/dental/medical): **Yes** ☐ **No** ☐

Any other relevant information that can help the Community Behavioral Health Team provide the student or family appropriate resources, services and treatment:

Identified student strengths:

II. Is the student experiencing any of the following concerns?

Reported symptoms related to depression or anxiety: **Yes** ☐ **No** ☐

Self-reported: ☐ Reported by parent/caregiver: ☐

Grief/loss: **Yes** ☐ **No** ☐

Self-reported: ☐ Reported by parent/caregiver: ☐

Violent/assaultive behaviors: **Yes** ☐ **No** ☐

Self-reported: ☐ Reported by parent/caregiver: ☐

Bullying, including social media bullying: **Yes** ☐ **No** ☐

Self-reported: ☐ Reported by parent/caregiver: ☐

Substance use: **Yes** ☐ **No** ☐

Self-reported: ☐ Reported by parent/caregiver: ☐

Self-harming behaviors: **Yes** ☐ **No** ☐

Self-reported: ☐ Reported by parent/caregiver: ☐

Thoughts of suicide within the past 30 days: **Yes** ☐ **No** ☐

Self-reported: ☐ Reported by parent/caregiver: ☐

Suicide attempts within the past 30 days: **Yes** ☐ **No** ☐

Self-reported: ☐ Reported by parent/caregiver: ☐

Was the student discharged from a psychiatric hospital within the past 30 days? **Yes** ☐ **No** ☐

Self-reported: ☐ Reported by parent/caregiver: ☐

Thoughts of harming another person within the past 30 days: **Yes** ☐ **No** ☐

Self-reported: ☐ Reported by parent/caregiver: ☐

Is the student receiving school-based mental health services at this time: **Yes** ☐ **No** ☐

If yes, what type of services?