MINNEAPOLIS SCHOOL BASED CLINICS program

Referral from School Staff

a program of the Minneapolis Health Department

Date _____

From:	***To:***
School Nurse _____ Teacher _____ School Social Worker _____ Counselor _____ Assistant Principal _____ Special Ed. _____ Other _____	_____ Nurse _____ Nurse Practitioner _____ Physician _____ Social Worker _____ Mental Health Therapist _____ Nutritionist _____ Lawyer _____ Harriet Tubman

Student Information

Student Name	Student ID#	Date of Birth

Signed Clinic Consent ___ Yes ___ No	Usual Source of Health Care	Parent Telephone Number

Reason For Referral:	***Comments***
____ acute or chronic care ____ personal counseling ____ health and wellness ____ nutritional services ____ laboratory services ____ chemical use ____ social work services ____ pregnancy services ____ family planning services ____ mental health services ____ health insurance ____ legal services ____ other	

Follow-up Plan

_____

_____

_____

_____

Student Signature:

I give permission for SBC staff and _____ to share pertinent information regarding my service needs and plan.

Student Signature _____ ***Date*** _____

Responded: ___ In Person ___ In Writing	Provider Signature	Date