GREENE ESC
GREENE COUNTY EDUCATIONAL SERVICE CENTER
Michael E. Gray, Superintendent • Robert L. Arledge Jr., Treasurer

MENTAL HEALTH SERVICES
Timothy J. Callahan, Psy.D.
Director

Name of Student: _____ DOB: _____ Gender: _____

Address: _____

Date of Referral: _____ Grade level: _____ District: _____ Building: _____

Mother/Guardian (s): _____

Parent Phone: (H) _____ (W) _____ (Cell) _____

Father/Guardian (s): _____

Parent Phone: (H) _____ (W)_____ (Cell) _____

Person Making Referral: _____ Phone: _____

Rating of Urgency: _____ 1= High (evidence of risk, etc.) to 5 = Low (on-going concerns that have not been responsive to school interventions) Explain:_____

Please check & attach copy of all that apply: ❑ IEP ❑ 504 ❑ ETR ❑ Behavior Plan ❑ IAT Notes

Reason for Referral: _____

_____

_____

Description of concerns: _____

_____

_____

Any previous counseling? Community agencies involved (FSC, TCN, CSB, BVR, etc. if known): _____

_____

Parent/guardian/student response to referral: _____

_____

Requesting more information: ❑Yes ❑No Willing to engage in services: ❑Yes ❑No

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To Be Completed by GCESC Mental Heath Staff

Date Referral Received by Clinician: _____

Notes:_____

The Greene County Educational Service Center has been accredited by CARF for all four of its mental health programs

Mental Health & Recovery Board of Clark, Greene and Madison Counties

Form Updated 7/2014