AHCCCS
Arizona Health Care Cost Containment System

School-Based Universal Referral Form

Referring Agency Information:

Referral Date:

Referring School: CTDS #:

Referring School Phone Number:

Referring Person Name: Position:

Referring Person Email:

Client Information:

Client Name: Client DOB:

Client Phone Number:

Parent/Guardian Name:

Parent/Guardian Phone: Best Time to Reach: AM | PM

Parent/Guardian Email:

Address:

Primary Language (Client): Primary Language (Guardian):

Referral being made due to substance use: Yes No Unsure

Is the student a:
Danger to Self (DTS) Danger to Others (DTO) Not Applicable

Reason for referral:

Other agency involvement: Dept. Child Safety Div Developmental Disabilities

Juvenile Probation Officer Other:

Consent:

By Checking Box – I, as a school staff member, have discussed my concerns with the Parents/Guardian and have been provided permission to make this referral.

Referring Person Signature: Date: