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: ☐ A.M. ☐ P.M.

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

If you are in crisis or need immediate assistance, please call 988 or 911.

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: