CCGC/SBS
1075 Tolland Turnpike
Manchester, CT 06042

Tel.: (860) 643-2101
Fax: (860) 432-8333

School Based Services Referral Form

Date	Referred By	Telephone Number	Fax or Email Address

Client Name:	Date of Birth	Grade:	School:

Parent/ Guardian Names	Primary Phone Number	Secondary Phone Number
# 1 # 2		

Address	Insurance Company	Insurance ID

Current Medications	Diagnosis	Previous Treatment

Presenting Problem

Other Important Information

"I understand that my signature gives the referring agency/person permission to share the above information with CCGC School Based Services and that this information will be used to determine eligibility for that program."

Parent/Guardian Signature: _____ Date: _____

Parent/guardian approval is required for submission/acceptance of referral.

If unable to obtain signature or submitting referral electronically please be sure to keep all protected health information (PHI) secure according to HIPPA regulations:

☐ As the referring person/agent I have reviewed this referral with the parent/guardian and I have their permission to submit this referral for the School Based Services Program.

Please fax or email referrals to Anisa S. Cole, LCSW at 860-43643-2101 or acole@ccgcinc.org