



**Miami-Dade County Public Schools  
 Department of Mental Health Services  
 Request for Referral for Contracted Mental Health Services**

**Referring Information**

School Name: \_\_\_\_\_ Location #: \_\_\_\_\_ School Ph. #: \_\_\_\_\_

Staff Contact Name: \_\_\_\_\_ Staff Title: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

**Student Being Referred**

Student Name: \_\_\_\_\_ ID #: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Steps Taken by School Prior to Referral (check all that apply)**

- \_\_\_\_\_ Student Conference
- \_\_\_\_\_ Parent Conference
- \_\_\_\_\_ Mental Health Team Convened

**Contracted Mental Health Agency Referred to:** \_\_\_\_\_

**Parent Consent/Mutual Exchange** \_\_\_\_\_ Yes \_\_\_\_\_ No

Referral cannot be made without receipt of FM-2128 (Consent for Mutual Exchange of Info.) Date Received: \_\_\_\_\_

**Type of Service Referred**

- \_\_\_\_\_ Screening/Assessment                      \_\_\_\_\_ Individual Counseling                      \_\_\_\_\_ Family Counseling
- \_\_\_\_\_ Counseling for Substance Abuse                      \_\_\_\_\_ Parent/Teacher Consultation                      \_\_\_\_\_ Case Management

School Administrative/Designee approval: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parties understand and agree that this referral is subject to all federal and state laws and School Board Policies relating to the confidentiality of student information. Parties further agrees to comply with the Family Educational Rights and Privacy Act ("FERPA"), 20 U.S.C. § 1232g, as may be amended. Parties shall regard all student information as confidential and will not redisclose student information to any additional third party.

FM-7740 and FM-2128 must be completed by the referring school and forwarded to:

- \_\_\_\_\_ Department of Mental Health Services - Attn: [mentalhealth@dadeschools.net](mailto:mentalhealth@dadeschools.net)
- \_\_\_\_\_ Agency
- \_\_\_\_\_ Parent/Guardian