**Student Referral Form**

**(all information is required)**

**Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_**

**Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male: \_\_\_ Female: \_\_\_**

**Legal guardian(s) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Legal guardian(s) Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Legal guardian(s) Email Address:\_**

**Legal guardian(s) Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Insurance (type and ID#):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred Language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is the legal guardian aware of this referral?: Yes \_\_\_ No\_\_\_**

 **Has a release been signed by the legal guardian?: Yes \_\_\_No\_\_ (Please attach release)**

**-If Yes, date of signature or verbal consent:\_\_\_\_\_\_\_\_\_\_\_**

**Does the student have an IEP or 504 Plan? Yes\_\_\_ No\_\_\_**

**School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student’s Teacher/Homeroom:**

**Name of Referral Source: \_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship (social worker, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Brief reason for referral:**

**Please email referral to:**

**BPSReferrals@wheelerhealth.org**

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| **REGISTRATION FORM** |
| **INFORMATION ABOUT THE PERSON BEING SEEN:** |
| First Name: | Last Name: | M.I. |
| Suffix:  | Date of Birth: | SSN: | Email: |
| Current Address:  |
| City: | State: | Zip Code: |
| Mobile #: | Home Phone #: | Work Phone: |
| APPOINTMENT REMINDERS: How may we contact you for appointment notices? (**Please check one)**  **** Mobile Calls **** Home Phone Calls **** Text Messages \*Messages and data rates apply  |
| **WHO MAY WE CONTACT IN AN EMERGENCY?** |
| Name: | Phone #: |
| Relationship: |
| **INSURANCE INFORMATION** – PLEASE PROVIDE INSURANCE CARDS TO THE FRONT DESK  |
| Health or Dental Insurance Company:  No Insurance |
| Policy ID #:  | Group #:  |
| **HOUSEHOLD INCOME** – HOUSEHOLD INCOME IS FOR GRANT REPORTING PURPOSES ONLY & NO PERSONALLY IDENTIFIABLE INFORMATION IS EVER REPORTED. THIS SECTION HELPS US TO RECEIVE FUNDING TO PROVIDE SERVICES TO THE COMMUNITY.  |
| **#** of people in your household: | Household income: $ **** Yearly / **** Monthly / **** Weekly |
| **DEMOGRAPHIC INFORMATION ABOUT CLIENT** – THIS INFORMATION HELPS INFORM US SO THAT WE MAY BETTER SERVE THE COMMUNITY. PLEASE SEE OUR NOTICE OF PRIVACY REGARDING THE SAFETY OF THIS INFORMATION. |
| Ethnicity: **** Non-Hispanic **** Hispanic **** Refuse to Report |
| Race: **** Native American **** Asian **** Black/African American **** Pacific Islander **** White **** Other  |
| Are you U.S. Military Veteran? **** Yes  **** No  |
| Do any of these situations apply to you? **** Migratory Worker **** Seasonal Worker \*If Homeless: **** Shelter **** Transitional Housing **** Double Up **** Street **** Other |
| Preferred Name:  | Birth Sex: **** Male **** Female |
| Gender Identity: **** Male **** Female **** Transgender Male  **** Transgender Female **** other **** Decline to disclose  | Preferred Pronoun: **** None **** He/Him/His  **** She/Her/Hers **** They/Them/Theirs **** Ze/Hir  |
| Sexual Orientation: **** Lesbian, Gay, or Homosexual **** Straight or Heterosexual **** Bisexual  **** Something Else  **** Don’t Know **** Decline to Disclose  |
| Religion: **** Christian **** Muslim **** Jewish **** Buddhist **** Hindu **** Other **** Unaffiliated  **** Decline to Disclose |
| **HOW BEST MAY WE COMMUNICATE WITH YOU?** |
| What is your Preferred language for discussing healthcare?  |
| Any Additional assistance required? **** TTY **** Interpretive services related to your language choice above  |
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