North Albany Wellness Center
110 Hickory St NW | Albany, OR 97321
541-760-2197 ph | 833-224-3845 fax
intake@northalbanywellnesscenter.com

Mental Health Referral from School

Date of referral: _____ Referred by: _____

School: _____

Student Name: _____ Date of Birth: _____

- ❑ Attach SIS Sheet, if available

Presenting Concerns:

_____

_____

_____

Date student/parent agreed to be contacted regarding mental health counseling services _____

Parent Name _____ Phone _____

Mailing/Home Address _____

Parent *Email* Address _____

Is the student 14 years of age or older? ☐ Yes ☐ No

Preferred appointment times (give two). We try to accomodate. _____

*****The following insurance information is ***very helpful*** in placing the student with a therapist.*****

Insurance Carrier: _____ ID Number _____

Subscriber: _____ Subscriber DOB: _____

Parent Concerns and/or Student Strengths:

_____

_____

_____

Please secure fax this form to: North Albany Wellness Center 833-224-3845