



## School Referral Form

\*\*This form doesn't guarantee eligibility for Rise-Up.

It is used for supportive information only

Participant's Name:		Date:	
School Name & Referring Staff:		Parent Contact Information:	
Reason for Referral & Support Seeking:		Special Needs/Custody Information	
Services in Place <i>(check all that apply)</i> : <ul style="list-style-type: none"> <li><input type="radio"/> Medication Management</li> <li><input type="radio"/> Counseling</li> <li><input type="radio"/> SUD Treatment</li> <li><input type="radio"/> CM/CBRS</li> <li><input type="radio"/> Groups</li> <li><input type="radio"/> Other: _____</li> </ul>	Residence: <ul style="list-style-type: none"> <li><input type="radio"/> Family</li> <li><input type="radio"/> Facility: _____</li> <li><input type="radio"/> Res Hab: _____</li> <li><input type="radio"/> Homeless</li> </ul>	Medications: <ul style="list-style-type: none"> <li><input type="radio"/> Has with them</li> <li><input type="radio"/> Home</li> <li><input type="radio"/> Facility</li> </ul> Pharmacy: _____	
Upcoming/Next Appointments:			
Rise-Up Intake Staff:		Eligibility Status:	
Notified of Eligibility Status:			

## Authorization for Release of Health Information

Member Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

This authorization expires in six months **unless noted otherwise:**

In one year  On date: \_\_\_\_\_

The person named above is or has been a patient of:

**Rise-Up  
Teen & Child Crisis Center  
1140 Science Center Dr.  
Idaho Falls, ID 83402  
Phone: 208-826-0994 Email: ybhccdirector@gmail.com Fax: 208- 845-6801**

The person named above hereby authorizes \_\_\_\_\_ to  
Name of Person, Provider, or Facility

Request health information from  Send health information to  Discuss health information with

**The person named above authorizes information to be requested or release by representatives of:**

Name of Person/  
Provider/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

### Scope:

All information regarding assessment, diagnosis, and treatment of member's condition, concern, or disease (specify): \_\_\_\_\_

All information regarding care received by member the dates of:  
\_\_\_\_\_ and \_\_\_\_\_  
Starting Date Ending Date

Other information (specify): Coordination & Continuity of Care

### Authorization

\_\_\_\_\_  
Printed name of Member & Authorized Representative

\_\_\_\_\_  
Signature of Parent Or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
Date