



Wallace Community College Referral

Wallace Campus: <input type="checkbox"/> Dothan <input type="checkbox"/> Eufaula				Online Yes <input type="checkbox"/> No <input type="checkbox"/>	
Student Being Referred:					
Student Number:			DOB:		
AGE:		RACE:		SEX:	
Date of Referral:			Insurance Info (if known):		
Student's Home Address:					
Home Phone:		Cell Phone:		Work Phone:	
Email:					

Concerning Behaviors (Mark Any That Apply)		
Reports Abuse	Victim of Crime or Violence	Suicidal Behaviors/Threats
Recent Traumatic Event	Peer/Social Problems	Parent/Child Conflict
Unusual Changes in Mood	Eating Problems	Substance Use Problems
Withdrawn/Depression	Recent Loss or Separation	Excessive Crying/Sadness
Angry/Agitated	Violent Outbursts	Fighting/Destroying Property
Resistant to Authority	Legal/Court Problems	High Risk Behaviors
Sexual Misconduct	Bullying (Perp/Victim)	Reports Sleep Problems
Inattentive/Hyperactive	Changes in Grades	Reports Fears/Phobias
Anxiety/Excessive Worry	Strange/Bizarre Behaviors	Reports Hallucinations
Notes:		
Has student agreed to referral for mental health services? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Referral submitted by:		Date:
Referring staff work phone:		

Save this document and upload to "Secure File Upload" by pressing this button.

www.spectracare.org/access-to-care