

## **PROJECT ASSIST**

Date:	Person	making referral:		
Referent Phone:		Referent Address:		
Child Name:			DOB:	M F
Ethnicity:		SSN:		
School:		Grade:	Phone:	
Parent(s):			Phone:	
Address:				
Medical Insurance (Name	and ID number	·):		
ı	Please indicate	yes or no for questions	below, if yes, please describe.	
School Issues	Υ	N		
Previous MH Tx	Υ	N		
Suicidal/Depression	Υ	N		
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Oppositional	Υ	N		
Sexuality Issues	Υ	N		

	Attention/Impulsive	Y	N			
	Aggressive	Υ	N			
	Anxiety	Υ	N			
	Bizarre Thinking/Behavior	Υ	N			
	Other Information:					
To refer a child, please complete this form, a signed release of information for Project Assist, and a completed Pediatric Symptom Checklist (PSC) form. Fax to 651-266-7875 or email to SSD.CMHProjectAssist@co.ramsey.mn.us.  Staff Use Only:						
	Date Received:			Date Assigned:		
Project ASSIST staff counselor assigned:						