METRO CARE CONNECTION
Cedar Rapids Community School District
School-Based Health Centers & Services

Metro Care Connection Referral Form

Metro Care Connection accepts referrals for school-based health care, mental health counseling and substance abuse counseling. These services are available to any CRCSD student. For **Health Care** (provided by Pediatric Nurse Practitioners in the school district) simply talk to the **school nurse or health secretary** in your building, or call one of our clinics:

Taylor School clinic	558-2481	Jefferson High School clinic	558-2221
Metro High School clinic	558-2272	Wilson School clinic	558-2003

When referring a student for:

- ⇨ **Substance Abuse Counseling** (School-based Metro Care/ASAC services)
  Complete the information below and place this form in the ASAC mailbox in your building. (If you have an ASAC referral on a middle school student, please call 390-4611 and ask for Cherie Duggan.)

Date:_____

Name of student being referred:_____

Name of school student attends:_____

Reason for referral to ASAC:

- ☐ Student Self-Referral
- ☐ Good Conduct Rule Violation/ Student Voluntary Admission
- ☐ Suspension- Related Referral
- ☐ Other _____

Person making referral (optional):_____

Phone number/room number of person making referral (optional):_____

If you have any questions, please call the Metro Care Connection Program Office at 558-2481. Thank you!

For Mental Health Counseling referrals (Abbe Center school-based therapy), please see the opposite side of this form.

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- **Mental Health Counseling** (Metro Care/Abbe Center school-based therapy)
  Complete the information and check list below, and contact the Metro Care/Abbe therapist assigned to your school. If you do not know or cannot contact that person, please call the Metro Care Connection Program Office at 558-2481. We request that you ensure that the student's parent/guardian is aware that a Metro Care/Abbe referral has been made.

Date:_____

Name of student being referred:_____

Name of school student attends and parent/guardian name and number:_____

_____

Reason for referral (for counseling fill out check list below):_____

_____

Person making referral: _____

Phone number/room number to contact person making referral (optional):_____

Abbe Referral Checklist

Please circle the behaviors you have seen in past 2 months:

Depressed/sad mood	**Self harm**	**Destructive to property**
Discouraged	**Defiant**	**Startles easily**
Appetite change (increase/decrease)	**Don't follow rules**	**Nightmares**
Loss of energy	**Blames others for behaviors**	**Experienced a trauma**
Falling asleep in class	**Angry**	**Impulsive behavior**
Agitated most days	**Argues with teachers**	**Short attention span**
Loss of concentration	**Headaches/stomach aches**	**Puts things off**
Feeling guilty when don't need to	**Dizziness**	**Poor concentration**
Feeling worthless	**Irritable**	**Fidgety/restlessness**
Feeling like there is no hope	**Restless**	**Easily frustrated**
Loss of interest in things once enjoyed	**Heart racing**	**Reactive**
Shows little motivation	**Tiredness/fatigue**	**Working below capacity**
Thinking is slowed	**Nervous/tense**	**Forgetful**
Increase in irritability	**Cruelty (people/animals)**	**Fails to complete tasks**
Crying	**Theft**	**Distractible**
Difficulty coping	**Aggression**	**Impatient**
Weight loss of 5 pounds or more	**Gets into fights**	**Hyperactive/on the go**
Suicidal thinking/talk	**Takes off from class/school**	**Excessive talking**
Don't appear to care much	**Truant**	**Poorly organized**

If you have any questions, please call the Metro Care Connection Program Office at 558-2481. Thank you!