

STERLING HEALTH CARE

Behavioral Health Referral Form

July 1st, 2025 - June 30th, 2026

Name of School: _____ Homeroom Teacher: _____

Name of student: _____ DOB: _____ Grade: _____

Your name: _____ Relationship to student: _____

Our provider may wish to contact you to discuss your referral concerns. Please provide your contact information and the best time to reach you.

Phone: _____ Best time to contact: _____

Area of concern (please describe):

___ Behavioral Concerns:

___ Social Concerns:

___ Emotional Concerns:

___ Physical Health Concerns:

___ Family Concerns:

___ Other: _____

Behavioral concerns (please mark all that apply):

___ Exposed to community violence, other

___ Hopelessness, negative view of future

___ Anxious, fearful or irritable mood

___ Jumpy or easily startled

___ Low or decreased motivation

___ Difficulty Sleeping

___ Sexualized play or behaviors

___ Talks excessively

___ Specific fears or phobias

___ Inattentive, distractible, forgetful

___ Disorganized, makes careless mistakes

___ Excessive sleeping (sleeping all day)

___ Sad, depressed or irritable mood

___ Low self-esteem, negative self-statements

___ Difficulty concentrating

___ Diminished interest in activities

___ Verbal Aggression

___ Physical Aggression

___ Worries excessively

___ Gets out of seat and moves constantly

___ Interrupts and blurts out responses

___ Clingy behavior

___ Angry towards others, blames others

___ Argumentative and defiant

How often is behavior occurring? _____

How long has this been occurring? _____

What interventions have been previously tried? _____

Have the parent(s)/guardian(s) been notified of the issue? ___ Yes ___ No

Contact information for parent(s)/guardian(s):

Name: _____ Phone: _____



CONSENT FOR SERVICES

Students Full Name

Date of Birth

Social Security #

At Sterling Health Care, we strive to provide the most comprehensive care possible for our patients. That is why we have expanded our services in your area and are partnering with Powell County Schools to offer school-based behavioral health services. Our providers will work to provide the best care possible for your child in the school setting.

In the process of providing school-based care our providers will only share patient information when clinically necessary to improve the overall well-being or safety of your child. Any pertinent information that is shared will only take place between our provider and the appropriate PCS staff member(s) to ensure the best clinical outcome and highest regard for protecting our patient's privacy.

In order to provide in school services, we will need you to complete the consent below:

I _____ give consent for my child _____
to receive school-based behavioral health services in the Powell County School system from Sterling Health Care.

I also give consent:

- For the Sterling Health Care staff to review my child's full school record, including attendance and information that will assist the staff in the continuity of care and treatment of my child.
- For Sterling Health Care staff to communicate and disclose behavioral health information with appropriate Powell County School Staff regarding my child's success at school and in the school setting.
- For Sterling Health Care School-Based Clinic to disclose to any appropriate agencies or medical practitioner any medical and billing information that may result through my child's contact with the School-Based Health Center.
- For the Sterling Health Care School-Based Clinic staff to obtain any records or information from any agency or private professional regarding my child's care. Sterling Health Care School-Based Clinic is released from all liability that may arise from the release of such information.
- I authorize Sterling Health Care to release medical information about me or my child to Medicare, KCHIP, Medicaid insurance and other third-party payers to determine payment for service.
- I request that payment of authorized medical insurance benefits be made to Sterling Health Care on my behalf for services received.

I understand that Sterling Health Care shall provide a copy of their Notice of Privacy Practices upon my request.

Parent/Guardian Signature

Date

STERLING HEALTH CARE

Authorization for Release of Information

The undersigned hereby authorizes:

Sterling Health Care
236 West Main Street
Mount Sterling, KY 40353
Ph: (859) 404-7686
Fax: (859) 498-8160

**to release to
(OR)
procure from**

*Powell County Schools
691 Breckinridge Street
Stanton, KY 40380*

Information from the below-listed patient/clinic record:

Patient Name: _____ Patient DOB: _____

Reason for Request:

☐ Personal Interest ☐ Continuity of Care ☐ Transferring Care ☐ Social Security/Disability Claim
☐ Legal Proceedings ☐ Insurance Claims Processing ☐ Other: _____

Date(s) of Service(s) to be released: _____

Medical Records:

I authorize the following information to be released:

☐ Visit Notes ☐ Visit Summary ☐ Immunization Record ☐ Medications ☐ Labs ☐ EKGs
☐ Chart Cover ☐ School/Work Excuse ☐ Other: _____

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon this authorization. This authorization will terminate on the following date, event, or condition: _____. If no date, event, or condition is specified, this authorization will expire **one year** from the signature date. I also understand that my refusal to sign this authorization will not affect my ability to obtain treatment, payment for services, or eligibility for benefits. If a service is requested by a party other than the patient for the purpose of creating health information, refusal to sign this authorization may result in the service request being denied.

I understand I can cancel this authorization, and to do so, I must send a written request to Sterling Health as authorized above.

I understand I can obtain a copy of my health care data, and to do so, I must submit a written request to Sterling Health as authorized above.

I understand that no treatment, payment, enrollment, or eligibility for benefits may be conditioned on whether I sign this authorization.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by federal law, **except for drug and alcohol treatment information.**

Printed Name: _____ Relationship to Patient: _____

Patient/Parent/Guardian/Legal Representative Signature: _____ Date: _____

Mental Health and/or Drug and Alcohol Treatment Records that are authorized to be released:

Please check the appropriate item(s):

☐ Psychotherapy Notes ☐ Psychosocial Assessment ☐ Treatment Plan ☐ Medications
☐ Group Therapy Notes ☐ Medication Management Notes ☐ Psychiatric Eval/Tests ☐ Psychosocial Eval/Tests
☐ Discharge Summary ☐ Labs ☒ Other (Please Specify): written and verbal communication
☐ Alcohol/Drug Treatment Records ☐ Alcohol/Drug Assessments ☐ Labs & Treatment Record

I understand that special permission must be given to release Mental Health/Drug and Alcohol/HIV results. I understand that by entering my signature below, I am releasing the detailed information to the above-listed person(s) or facility.

**** I understand that my health information is protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the HIPAA Privacy Law. ****

Printed Name: _____ Relationship to Patient: _____

Patient/Parent/Guardian/Legal Representative Signature: _____ Date: _____

FOR FACILITY PERSONNEL ONLY:

☐ Patient Identification Verified. Signature: _____ Date: _____



STERLING HEALTH CARE - CHILD

GUARDIANSHIP INFORMATION

Are you the child's legal guardian? ☐ Yes ☐ No

If you marked no, who has legal guardianship? _____

****If you are not the biological or adoptive parent, you must provide legal documentation of guardianship****

DEMOGRAPHIC INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Nickname: _____ SSN: _____ Birth Date: _____

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ White
☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Non Hispanic/Non Latino

Preferred Language: ☐ English ☐ Spanish ☐ Interpreter Needed

Address: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Preferred Communication: Phone/Email

Preferred Phone Contact: ☐ Home ☐ Cell ☐ Work

Living Situation ☐ Homeless ☐ Transitional ☐ Doubling Up ☐ Street ☐ Other ☐ Unknown ☐ Not Homeless

Agricultural Worker ☐ Migrant ☐ Seasonal Are you a Veteran ☐ Yes ☐ No

In case of Emergency, please contact:

Name _____ Phone: _____ Relation: _____

Address _____

INSURANCE INFORMATION:

Do you have insurance: Yes No (if no, sliding scale fee available)

Primary Insurance: _____ ID# _____ GROUP# _____

Secondary Insurance: _____ ID# _____ GROUP# _____

Subscriber Name: _____ Subscriber Date of Birth _____

Subscriber Gender: ☐ Female ☐ Male Subscriber Phone: _____ SSN#: _____

Subscriber Address if different from Patient: _____

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CHILD NEW PATIENT HISTORY

ALLERGIES

Medications	
Vaccines	
Food	
Other	

CURRENT MEDICATION(S)

Medication Name	Dosage	Directions

BIRTH HISTORY

Was this child? ☐ Full term ☐ Pre-term ☐ Adopted

If pre-term, how many weeks? _____ If adopted, at what age? _____

Type of delivery? ☐ Vaginal ☐ C-section If C-section, why? _____

Birth weight _____ Breech? ☐ Yes ☐ No

Any problems during the newborn period? ☐ Yes ☐ No

If yes, please explain _____

Developmental Milestones

At what age did your child: Crawl _____ Walk _____ Talk _____

Dress themselves _____ Feed themselves _____

Does your child have any motor skill functioning issues? _____

CHILD'S PAST MEDICAL HISTORY

Previous Diagnosis and Dates of Diagnosis:

Any Hospitalizations? (Including Psychiatric) ☐ Yes ☐ No

Reason for Hospitalization	Date of Hospitalization	Facility Where Hospitalized

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Any Surgeries? ☐Yes ☐No

Type of Surgery	Date of Procedure	Facility Where Procedure Was Performed

FAMILY HISTORY

Is there a family history of mental health or substance abuse issues? __Yes __No

If so please list what and who: _____

SOCIAL HISTORY

Who lives in your child's home? _____

Is your child in: ☐Daycare ☐School If so, what grade? _____

Do you have any concerns about your child's behavior? _____

Is there anything more you would like us to know about your child? ☐Yes ☐No

If yes, please explain _____
