School Contact

Please provide some basic information about who is referring the student.

Referral Date *
08/13/2024

School Contact *

First Name *
Jillian

Last Name *
Kocialski

Contact Number *
(316) 393-3128

Extension (Optional)

Email Address *
tchattuthsct@gmail.com

Alternate School Contact

First Name

Last Name

Contact Number

Extension (Optional)

Email Address

This is for any additional person you would like for us to send the appointments to.

School Name *

School District
HUGHES SPRINGS ISD

TEA ID

Does your campus support on campus appointments?

Yes No

Student Details

Please provide some basic information about the student you are referring.

Personal Information

First Name *

Last Name *

Date of Birth *
MM/DD/YYYY

Age
0

Age is calculated at time of referral

Gender *

Male Female Other

Ethnicity *

Race *

Does this student have an intellectual or developmental disability? *

Yes No Unsure

School Information *

Grade *

Student ID (optional)

Even though this doesn't have a star, we do require it.

Contact Information (optional)

Contact Number

Preferred Language *

Preferred Pronoun

Email Address

Home Address

Zip Code

State
Texas

Street Address

Suite/Room

City

Parent/Legal Guardian

Not more than 2 Parent/Legal Guardian can be added

Required if the patient is under 18.

Parent/Legal Guardian 1

First Name *

Last Name *

Family Relation *

Primary Contact Number *

☐ Mobile?

Email Address *

☐ No email available

Preferred Language *

Does the parent share the same address as the student?

◯ Yes ◯ No

☐ Student's emergency contact

+ Add Parent/Guardian.

Call Preference

Please select a time preference to call back the patient or parent/guardian.

Select at least one time from Morning or Afternoon. *

Morning	Afternoon	Evening
☐ 8am to 9am	☐ 12pm to 1pm	☐ After 5pm
☐ 9am to 10am	☐ 1pm to 2pm	**Note:** Services may not be available after business hours
☐ 10am to 11am	☐ 2pm to 3pm	
☐ 11am to 12pm	☐ 3pm to 4pm	
	☐ 4pm to 5pm	

☐ No Preference

Reason for Referral

Please select a reason for referral.

Has student experienced any of the following? *

- ☐ Academic issues/Truancy
- ☐ Anger
- ☐ Aggression/Violence
- ☐ Anxiety/Excessive worry
- ☐ Appetite/Eating
- ☐ Attention problems
- ☐ Bereavement/Grief
- ☐ Bullying
- ☐ Depression
- ☐ Disruptive behaviors
- ☐ Hallucinations
- ☐ (Low) Self-esteem
- ☐ Self-harm
- ☐ Sleep issues
- ☐ Substance issues
- ☐ Suicidal thoughts
- ☐ Trauma
- ☐ None of the above (Review options before selecting and specify below)

Some of these, when selected, may see a message appear referencing your school crisis plan. A student in an emergent state in need of immediate services is not an appropriate TCHATT referral. Please reference your school crisis plan in those instances.

Additional Information

Please provide any additional information that would help facilitate effective TCHATT services to this family.

Notes about referrals.

Please input the following:

- *Availability for scheduling sessions with a student*
- *If the parent is ok with us texting*
- *If the student has a 504/IEP*
- *Other important information*

Documents

Drag the DOC, DOCX, PDF, JPG, CSV, XLS, or XLSX file.

Select File

Please select the documents you want to send. You can select and send multiple documents

Submit