School Contact

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

School Contact * First Name * Jillian Last Name * Kocialski Contact Number * (316) 393-3128							08/13/2024
Kocialski Contact Number * (316) 393-3128 Email Address * tchattuthsct@gmail.com Alternate School Contact First Name Last Name Contact Number Extension (Optional) Email Address Q School Name * School District HUGHES SPRINGS ISD TEA ID Does your campus support on campus appointments? Yes O No Personal Information First Name * Last Name * Date of Birth * MM/DD/YYYY Age 0						*	First Name *
Email Address * tchattuthsct@gmail.com Alternate School Contact First Name Last Name Contact Number Email Address Contact Number Extension (Optional) Email Address Q School Name * School District HUGHES SPRINGS ISD TEA ID Does your campus support on campus appointments? Yes No Personal Information First Name * Last Name * Date of Birth * MM/DD/YYYY Age 0							
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Last Name * Date of Birth * MM//DD/YYYY Age 0						rmation	Personal Inform
Date of Birth * MMI/DD/YYYY Age 0							First Name *
MM/DD/YYYY 0							Last Name *
Age is calculated at time of referral							
						nted at time of r	
Gender *							Gender *

Student Details

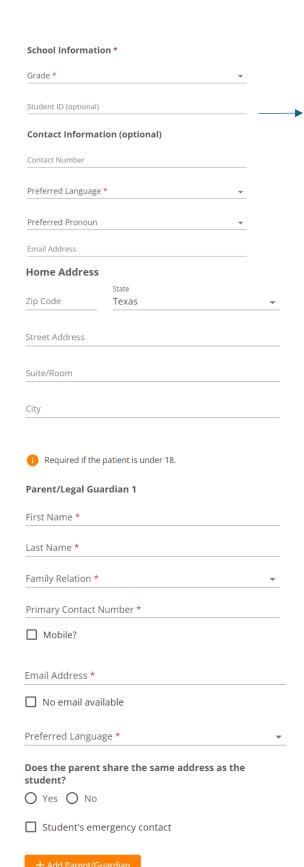
Please provide some basic information about the student you are referring.

Ethnicity *

Race *

Does this student have an intellectual or developmental disability? *

O Yes O No O Unsure



Parent/Legal Guardian

Not more than 2 Parent/Legal Guardian can be added

Even though this doesn't

have a star, we do require

Call Preference	Select at least one time from Morning or Afternoon.*				
Please select a time preference to call back the patient or parent/guardian.	Morning	Afternoon	Evening		
	8am to 9am	☐ 12pm to 1pm	After 5pm Note: Services may		
	9am to 10am	☐ 1pm to 2pm	not be available after business hours		
		2pm to 3pm	243.11233.1134.13		
	☐ 11am to 12pm	3pm to 4pm			
		4pm to 5pm			
	☐ No Preference				
Reason for Referral	Has student exp	perienced any of	the following? *		
Please select a reason for referral.	Academic issu	es/Truancy			
	☐ Anger				
	☐ Aggression/Vio	olence			
	☐ Anxiety/Excess	sive worry			
	☐ Appetite/Eatin	g			
	☐ Attention prob	olems	Some of these, when selected, may see a message appear		
	☐ Bereavement/	Grief		referencing your school crisis	
	Bullying		_	plan. A student in an emergent state in need of immediate	
	Depression			services is not an appropriate	
	☐ Disruptive beh	aviors		TCHATT referral. Please reference your school crisis	
	☐ Hallucinations			plan in those instances.	
	(Low) Self-este	em			
	Self-harm				
	☐ Sleep issues				
	☐ Substance issu	ies			
	☐ Suicidal though	hts			
	☐ Trauma				
	None of the ab (Review option	oove is before selecting a	nd specify below)	Please input the following: - Availability for scheduling sessions	
Additional Information Please provide any additional information that would help facilitate effective TCHATT services to this family.	Notes about refe	rrals.		with a student - If the parent is ok with us texting - If the student has a 504/IEP - Other important information	
_				Illioilliadoll	
Documents					
Drag the DOC, DOCX, PDF, JPG, CSV, XLS, or XLSX file.					
			Select File		
		ase select the documents altiple documents	you want to send. You can se	elect and send	

Submit