Scranton Counseling Center Crisis Department fax: 570-706-2740
SCC Crisis Worker at Geisinger Community Medical Center fax: 717-754-0995
Geisinger CMC Behavioral Health Specialist Cell Phone: 570-452-9033
Lackawanna-Susquehanna BHIDEI Program fax: 570-963-6435

Student Suicide Risk /Violence Risk Crisis Referral Form:

<table>
<tr><th colspan="2">Student Information</th></tr>
<tr><td>Student Name (please print):

Today's Date:</td><td>Name of School (please specify district name and elementary, intermediate, high school, etc.):</td></tr>
<tr><td>Male: Female: Non-Binary:</td><td>Date of Birth: Grade:</td></tr>
<tr><td colspan="2">Parent address/phone # & notification date and time:

Response (i.e., arrived at school, authorized transport to hospital, etc.) :</td></tr>
<tr><th>Referral Source (check one)</th><th>Reason for Referral (check one)</th></tr>
<tr><td>Name and title of person that initiated referral (please print):____

____

___ Friend/student
___ Parent
___ Teacher
___ Self-Referral
___ Other______________________________________</td><td>___ Suicidal behavior (any action that could cause a person to die, such as taking a drug overdose or crashing a car on purpose).
___ Suicide Threat (a statement of intent to die by suicide accompanied by behavior changes indicative of suicidal tendencies).
___Suicidal ideation(thoughts of engaging in behavior intended to end one's life).
___ Student has made threats or there are concerns of violence (be specific)__________________________________
____</td></tr>
<tr><td colspan="2">Student assessed by school personnel: (Name/title/agency/phone number):

School Email for Crisis Follow-Up:</td></tr>
<tr><td colspan="2">Student transported to:</td></tr>
<tr><td colspan="2">Form completed by (Print Name): ____Date:</td></tr>
<tr><td colspan="2">Signature:</td></tr>
<tr><td colspan="2">Reason for Crisis Referral (Summary)::</td></tr>
</table>

Signature of Parents permission to share with evaluator (if student is under age 14):

Signature____ Date:____________________