



# Community Integrated Health Services

## Student Threat Assessment Care Coordinator (S-TACC) Referral Form

**Attn: Javin French**  
**Phone Number: (360) 623-0815**  
**Fax Number: (844) 554-3370**

**Instructions:**

- Fax this form to Javin French, School Threat Assessment Care Coordinator: **(844) 554-3370**
- **Include Form No. 001-1** (Authorization To Use or Disclose Protected Health Information Form)

**To be completed by referring party:**

Date of Referral: _____	Student Phone #: _____
Student Name: _____	Student Email: _____
DOB: _____	Parent/Guardian 1 Name: _____
Age: _____	Parent/Guardian 2 Name: _____
Current Behavioral Health Provider: _____	Parent/Guardian 1 Phone #: _____
	Parent/Guardian 2 Phone #: _____
	Parent/Guardian 1 Email: _____
	Parent/Guardian 2 Email: _____
School District: _____	Primary School Contact Name: _____
School: _____	Primary School Contact Email: _____
Referring Staff: _____	Primary School Contact Phone #: _____
Reason for referral:	

**To be completed by CIHS/S-TACC REFERRAL Team**

**Decision by CIHS-S-TACC REFERRAL:**

**Accept:**  **Date:** \_\_\_\_\_

**Transition Plan:** \_\_\_\_\_

**Deny:**  **Date:** \_\_\_\_\_

**If denied, CIHS will record the reason for the denial and provide recommendation for individual's care:**

**Rational of denial:** \_\_\_\_\_

**Recommendations/Resources:** \_\_\_\_\_