ACI Enterprises Inc.
6480 Weathers Place, Suite 300, San Diego, CA 92121
ACI Clinical Dept: clinical@acispecialtybenefits.com
Tel: (800) 932-0034 | Fax: (858) 964-0733

STUDENT FORMAL REFERRAL FORM

PLEASE PRINT OR TYPE

Student Name:	**School Name:**	
School Location:	**Student ID #:**	**Date of Referral Submission:** / /
Student Phone #:	**Student Email:**	**Student Zip Code:**
Detailed Reason for Referral:		

☐ **Standard Referral**	ACI will contact a provider within 2 business days of the submission date above. The student will contact the referred provider within 3-5 business days to schedule an appointment.
☐ **Urgent Referral***	ACI will contact a provider by the end of the business day immediately following the submission date above. The student will contact the referred provider within 2-5 business days to schedule an appointment.

***Mark urgent only when an employee is in a serious situation, produces a positive drug screen, or is placed on leave until assessed by a provider. If you think the employee may be in a current state to harm him/herself or others, you should call 911 to get assistance from local authorities.**

I understand and agree that a condition of continued school enrollment may be that I contact ACI Specialty Benefits at 800-932-0034 to begin the formal referral process. I will complete the course of treatment as recommended or arranged through the provider, and cooperate with any such assessment, treatment or care. I acknowledge that my signature below indicates my acceptance of these terms. I understand that this is a release of confidentiality and privilege.

Student Signature:	**Date:** / /

School Representative Signature:		**Date:** / /
School Rep. Name:	**School Rep. Phone #:**	**School Rep. Email:**

PRINT FORM **SUBMIT FORM**

ORIGINAL: Referring School Representative's File
COPY: Student

Fax: (858) 964-0733
Email: clinical@acispecialtybenefits.com

www.acispecialtybenefits.com

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