



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:	

Has the student been suspended from or currently on any sort of leave of absence? If yes, please provide the type of leave and effective date.

Suspended/Leave of Absence: <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Leave:	Effective Date: / /
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Detailed Reason for Referral:

<input type="checkbox"/>	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.
<input type="checkbox"/>	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:

ORIGINAL: Referring School Representative's File
COPY: Student

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