DeSoto County Schools
Request for Mental Health Consultation

Counselor/Admin. Requesting Services _____ School _____ Date _____

STUDENT'S RESIDENCE: ☐ Parent/Guardian ☐ Resident/Children's Home ☐ Foster Parent ☐ Other:____

Student's Name _____
Gender _____ D.O.B. _____ Grade _____
Student's Home Address _____
SPED Eligibility/Ruling (If Applicable) _____
Medicaid/Insurance # (if known) _____

Mother's Name _____Mother's Phone _____
Mother's Home Address (if different from student) _____

Father's Name _____ Father's Phone _____
Father's Home Address (if different from student) _____

In Legal Custody of _____ Phone _____
Relationship to student _____
Parent/Guardian E-Mail Address _____

Teacher's/Counselor's/Administrator's Description of Mental Health Concern:

_____
_____
_____
_____
_____

Actions Taken Prior to Request for Services:

_____
_____
_____
_____

Send this Request Form to **Tajuana Williams** at Central Services.
(Phone: 662-449-7299 or Fax: 662-449-1429)
Date received and Approved at Central Services: _____