ASPIRE
DeComplicate DeStress

Student Formal Referral Form

STUDENT NAME _____ SCHOOL NAME _____

LOCATION _____ STUDENT ID # _____

HOME # _____ CELL # _____

EMAIL _____ DATE OF REFERRAL SUBMISSION _____

REASON FOR REFERRAL _____

Release of Information

I understand and agree that I may contact the ASPIRE Hotline at 888-470-1531:

	Standard Referral	Within 2 business days of the date above and schedule an appointment within 3-5 business days
	Urgent Referral*	By the end of business day immediately following above date, and schedule an appointment within 2-5 business days

**For emergencies, always use 911. Urgent referrals are to be used only if same day clinical response is required. Most requests should fall under standard category.*

I will complete the course of treatment as recommended or arranged through ASPIRE, and cooperate with any such treatment, counseling or recommendations. I indicate my acceptance of these terms and authorize my school representative (identified below) and the ASPIRE Program Administrator, by my signature below, to exchange information regarding this referral. I understand that this is a release of confidentiality and privilege.

STUDENT SIGNATURE _____ DATE _____

SCHOOL REPRESENTATIVE SIGNATURE _____ DATE _____

SCHOOL REP. NAME (PLEASE PRINT) _____ STUDENT ZIP CODE _____

SCHOOL REP. CONTACT PHONE # _____ EMAIL _____

□ ORIGINAL: STUDENT'S ACADEMIC FILE.
□ COPY: STUDENT
□ FAX: ACI 858-964-0733

ONLY TREATMENT RECOMMENDATIONS THAT PROVIDER DETERMINES ARE CONNECTED TO THE SCHOOL REFERRAL WILL BE MONITORED BY ASPIRE.

ACI's Clinical Department
Phone: **888-470-1531**
Fax: **858-964-0733**
Email: **clinical@acispecialtybenefits.com**

ACI SPECIALTY BENEFITS