Client ID____________________

DOB________________________

REFERRAL FORM

Teacher/Educational Resource

Name of student: ____

Your name: ____

Relationship to student: ____

The school's problem-solving team may wish to contact you to discuss your referral concerns. Please provide your contact information and the best time to reach you.

Phone:_________________________ Best time to contact:_________________________

Area of concern (please describe):

- ☐ Academic Concerns:
- ☐ Behavioral Concerns:
- ☐ Social Concerns:
- ☐ Emotional Concerns:
- ☐ Physical Health Concerns:
- ☐ Family Concerns:
- ☐ Other: _____________________

Behavioral concerns (please mark all boxes that apply):

- ☐ Exposed to community violence, other trauma
- ☐ Nightmares, intrusive thoughts
- ☐ Anxious, fearful or irritable mood
- ☐ Jumpy or easily startled
- ☐ Avoids reminders of trauma
- ☐ Aggressive
- ☐ Sexualized play or behaviors
- ☐ Difficulty concentrating

- ☐ Talks excessively
- ☐ Gets out of seat and moves constantly
- ☐ Interrupts and blurts out responses
- ☐ Inattentive, distractible, forgetful
- ☐ Disorganized, makes careless mistakes
- ☐ Angry towards others, blames others
- ☐ Fights and is aggressive
- ☐ Argumentative and defiant

- ☐ Sad, depressed or irritable mood
- ☐ Hopelessness, negative view of future
- ☐ Low self-esteem, negative self-statements
- ☐ Difficulty concentrating
- ☐ Diminished interest in activities
- ☐ Low or decreased motivation

- ☐ Anxious and fearful
- ☐ Worries excessively
- ☐ Difficulty sleeping
- ☐ Restless and on edge
- ☐ Specific fears or phobias
- ☐ Difficulty concentrating
- ☐ Clingy behavior
- ☐ Appears distracted

Client ID____________________

DOB________________________

How often is this behavior occurring? (e.g., several times per day; 1-2 times per week)

How long has this behavior been occurring? (e.g., several weeks, several months)

To your knowledge, what interventions have previously been tried?

- In school supports:
  ____
  ____
  ____
- Outside of school supports:
  ____
  ____
  ____

To your knowledge, what interventions are currently in place?

- In school supports:
  ____
  ____
  ____
- Outside of school supports:
  ____
  ____
  ____

What do you think will help the student to experience success?

Client ID____________________

DOB________________________

REFERRAL FORM

By Parent or Guardian

Date: ____

Name of child: ____

Your name: ____

Relationship to child: ____

The school's care team may wish to contact you to discuss your referral concerns. Please provide your contact information and the best time to reach you.

Phone: ______________________________ Best time to contact: ________________________

Who does your child live with?

- ☐ Biological parents
- ☐ Adoptive parents
- ☐ Foster parents
- ☐ Relative care
- ☐ Group home
- ☐ Other: ____________________

Desired language of service?

- ☐ English
- ☐ Spanish
- ☐ Other: ____________________

Does your child have an individualized education plan (IEP)?

- ☐ Yes
- ☐ No
- ☐ I don't know

Area of concern (please describe):

- ☐ Academic Concerns:
- ☐ Behavioral Concerns:
- ☐ Social Concerns:
- ☐ Emotional Concerns:
- ☐ Physical Health Concerns:
- ☐ Family Concerns:
- ☐ Other: _____________________

Behavioral concerns (please mark all boxes that apply):

- ☐ Exposed to community violence, other trauma
- ☐ Nightmares, intrusive thoughts
- ☐ Anxious, fearful or irritable mood
- ☐ Jumpy or easily startled
- ☐ Avoids reminders of trauma
- ☐ Aggressive
- ☐ Sexualized play or behaviors
- ☐ Difficulty concentrating
- ☐ Talks excessively
- ☐ Gets out of seat and moves constantly
- ☐ Interrupts and blurts out responses
- ☐ Inattentive, distractible, forgetful
- ☐ Disorganized, makes careless mistakes
- ☐ Angry towards others, blames others
- ☐ Fights and is aggressive
- ☐ Argumentative and defiant

Client ID____________________

DOB_______________________

- ☐ Sad, depressed or irritable mood
- ☐ Hopelessness, negative view of future
- ☐ Low self-esteem, negative self-statements
- ☐ Difficulty concentrating
- ☐ Diminished interest in activities
- ☐ Low or decreased motivation

- ☐ Anxious and fearful
- ☐ Worries excessively
- ☐ Difficulty sleeping
- ☐ Restless and on edge
- ☐ Specific fears or phobias
- ☐ Difficulty concentrating
- ☐ Clingy behavior
- ☐ Appears distracted

How often is this behavior occurring? (e.g., several times per day; 1-2 times per week)

How long have you had this concern about your child?

To your knowledge, has your child ever received any supports or interventions for this behavior in the past?

To your knowledge, is your child receiving any supports or interventions for this behavior currently?

What do you think will help your child experience success?

Client ID____________________

DOB_______________________

REFERRAL FORM

Self-Referring

Date: ____

Your name: ____

Who are you looking for support for?

- ☐ Myself
- ☐ Another student at my school

The school's care team may wish to contact you to understand your concerns better.

- ☐ Yes, it's ok to contact me
- ☐ No, please don't contact me

Please share the reason you are seeking support for yourself or another student:

____

Please mark all boxes that apply:

- ☐ Exposed to community violence, other trauma
- ☐ Nightmares, intrusive thoughts
- ☐ Anxious, fearful or irritable mood
- ☐ Jumpy or easily startled
- ☐ Avoids reminders of trauma
- ☐ Aggressive
- ☐ Sexualized play or behaviors
- ☐ Difficulty concentrating

- ☐ Talks excessively
- ☐ Gets out of seat and moves constantly
- ☐ Interrupts and blurts out responses
- ☐ Inattentive, distractible, forgetful
- ☐ Disorganized, makes careless mistakes
- ☐ Angry towards others, blames others
- ☐ Fights and is aggressive
- ☐ Argumentative and defiant

- ☐ Sad, depressed or irritable mood
- ☐ Hopelessness, negative view of future
- ☐ Low self-esteem, negative self-statements
- ☐ Difficulty concentrating
- ☐ Diminished interest in activities
- ☐ Low or decreased motivation

- ☐ Anxious and fearful
- ☐ Worries excessively
- ☐ Difficulty sleeping
- ☐ Restless and on edge
- ☐ Specific fears or phobias
- ☐ Difficulty concentrating
- ☐ Clingy behavior
- ☐ Appears distracted

Please share any additional information you would like the care team to know: