**Emery USD COST**

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| **NOTE: If you suspect Child Abuse or Neglect YOU MUST notify CPS (510) 259-1800** |

**REFERRAL FORM**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **STUDENT INFORMATION:** | | | | | | | | | | | | | | | |
| (Student Name) | | | | | Teacher | | | | Grade | | Date of Birth | | | | Sex (M/F) |
| Ethnicity:       Is student aware that you are making this referral? Yes No  Referred By:       Title:       Date: | | | | | | | | | | | | | | | |
| 1. **PARENT(S) / GUARDIAN(S) INFORMATION:** | | | | | | | | | | | | | | | |
| (Parent/Guardian Name) | | | | Relationship | | | | Street Address | | | | | | Zip Code | |
| (Home) | | (Work) | | | | (Cell) | | | | (Other) | | | | | |
| Primary Language Spoken at Home? | | | | | | | | | | | | | | | |
| Has the family been informed that you are making this Referral? Yes No If so, who? | | | | | | | | | | | | | | | |
| 1. **REASON FOR REFERRAL (check all that apply)** | | | | | | | | | | | | | | | |
| **Academic/School Needs** | **Emotional/Behavioral Needs** | | | | | | **Social Rel’ship Needs** | | | | | **Health/Basic Needs** | | | |
| Attendance/ Truancy  Academic Concerns  Behavior in Classroom  Suspensions  Expulsions  Learning difficulties  Attention issues/lack of  focus | Anger Management  Self esteem/self image/self worth  Possible depression  Suicidal thoughts or feelings  Self-injury/ mutilation/cutting  Violence Related Issues  Maladaptive response to trauma  Grief Related Issues | | | | | | Parent-Family-Child  Relationships/Conflicts  Gender Identity Issues  Dating/Partner Issues  Sexualized Behavior  Sexual Harassment  Gang Involvement  Child in Foster Care  Peer Conflict/Bullying | | | | | Eating Issues  Substance Abuse/ Use  Basic Needs (food,  shelter, clothing)  Health Issues (vision,  dental, etc.  Other, describe  below | | | |
| **Please provide a brief description of the reason for referral: (If requesting an SST, please describe concerns & reason)** **SST Request** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| 1. **ADDITIONAL SERVICES** | | | | | | | | | | | | | | | |
| **District Services** | | | | | | **Community Services** | | | | | | | | | |
| Does student currently have or been referred to:  SST ………………………………...….. Yes No Unsure  Active IEP ….……………..…………... Yes No Unsure  Special Education Assessment................ Yes No Unsure  SARB/SART…………………………... Yes No Unsure  504……………………………………... Yes No Unsure | | | | | | To the best of your knowledge, is the student and/or the family working with anyone else on this issue? (Therapy, Outside Community Provider)  Yes No Unsure  If so, who? | | | | | | | | | |
| **To the best of your knowledge, does this student / family have health coverage of any kind?**  (e.g.: Medi-Cal, Healthy Families, Kaiser Permanente, etc.)  Yes No Unsure | | | | | | | | | |
| 1. **FOR COST USE ONLY:** | | | | | | | | | | | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name/Service Referred to | | | Title | | | | | | Date | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Referral Received | | |

**COST**

**CONFIDENTIAL**

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1. **PARENT/CARETAKER CONTACT:**

**Date of Contact Type of Contact Reason for Contact & Outcomes, if any.**

1. **INTERVENTIONS/MODIFICATIONS:**

**Please list intervention/modifications and detail their outcomes:**

**Additional Time to Complete Assignments** **Leave Class for Assistance** **Computer** **Proximity**

**Frequent Breaks** **Seating Change** **Audio Texts** **Redirection**

**Simplify Assignments** **Mixed Grouping** **Visual Aids** **Eye Contact**

**Shorten Assignments** **Cooling Off Period** **Manipulatives** **Listening**

**Chunking Work** **Planned Ignoring for**

**Oral Responses Negitive Atttention Seeking**

**Tutoring** **Positive Reinforcement for**

**Teach/Reteach Expectations Appropriate Behaviors**

**Other Please Explain:**

Other Pertinent Information:

*Updated 10/15/18*