FULL SERVICE SCHOOLS
REFERRAL FOR SERVICE(S)

Referral Date:_____.

Student Name: _____Student Number: _____ School: _____

Grade Level: ____ Age: ____D.O.B.: _____ Gender: _____Race/Ethnicity: _____

Address:_____Zip Code: _____

Classroom/Homeroom Teacher:_____ ESE Designation: _____

For DCPS Staff Use Only: PARENT/LEGAL GUARDIAN MUST BE NOTIFIED AND CONSENT TO REFERRAL PRIOR TO STUDENT BEING REFERRED FOR SERVICES**

Parent/Legal Guardian Notified of Referral? ☐ **Yes** ☐ **No** Parent/Legal Guardian Provided Consent for Referral? ☐ **Yes** ☐ **No**

Consenting Parent/Legal Guardian Name:_____Date of Consent for Referral:_____

Please mark the following area(s) of concern/services needed and explain in the comment section:

CLASSROOM CONDUCT:

- ☐ Disruptive
- ☐ Defiant
- ☐ Skipping
- ☐ Inappropriate Responses
- ☐ Excessive Absenteetism
- ☐ Sleeping in Class

BEHAVIOR(S) OBSERVED:

- ☐ Negative attitude
- ☐ Self-Harm Behaviors
- ☐ Mood Swings
- ☐ Suicidal/Homicidal Thoughts
- ☐ Withdrawn (loner)
- ☐ Depressed mood (sad)
- ☐ Extreme weight loss/gain
- ☐ Poor Social Skills
- ☐ Anger
- ☐ Bullying
- ☐ Physical aggression
- ☐ Defensiveness
- ☐ Difficulty Accepting mistakes
- ☐ Gang/Occult Related Drawings/ Symbols and Affiliation

ACADEMIC PERFORMANCE:

- ☐ Declining Quality of Work
- ☐ Academic Failure
- ☐ Lack of Motivation
- ☐ Unrealistic expectations
- ☐ Lack of Concentration/Attention Focus

CLASSROOM CONDUCT:

- ☐ Divorce/Separation
- ☐ Poor Relationships
- ☐ Grief/Loss
- ☐ Negative Influences
- ☐ Abuse/Neglect
- ☐ Low Self-Esteem
- ☐ Recently Moved to the Area
- ☐ Sexual Identity/Orientation (Struggles/Self Referrals)

ALCOHOL/DRUG USE:

- ☐ Suspected Use, Possession, Distribution, or Sale of Tobacco, Alcohol, or Other Drugs

HEALTH & WELLNESS SERVICE NEED:

- ☐ Individual Counseling
- ☐ Group Counseling
- ☐ Mentoring
- ☐ Teen Parent Services
- ☐ Medical
- ☐ Food
- ☐ Vision
- ☐ Clothing

OTHER/COMMENT (REQUIRED):

_____

_____

_____

Is the student receiving services from another agency? ☐ **Yes** ☐ **No**
If yes, list agencies and contact names (if known):

_____

For School Use Only: Has the student been referred to the Threat Assessment Team? ☐ **Yes** ☐ **No**

REFERRAL SOURCE:

- ☐ Self-referral by Parent/Guardian
- ☐ Self-Referral by Student
- ☐ Referred by Other

PARENT/GUARDIAN CONTACT:

Name:_____

Relationship to Student:_____

Telephone:_____

Email:_____

FORM COMPLETED BY:

Name:_____

Title/Position:_____

Telephone/Fax:_____

Email:_____