2022-23 FULL SERVICE SCHOOLS ASSESSMENT FOR SERVICE(S)

Full Service Schools OF JACKSONVILLE

DUVAL COUNTY PUBLIC SCHOOLS

Referral Date:_____

Student Name: _____Student Number: _____ School: _____

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

Address:_____ Zip Code: _____

ESE Designation: ○N/A ○SI ○SLD ○OHI ○OI ○LI ○ID ○HH ○G ○EBD ○DD ○DHH ○ASD ○504 ○TBI ○VI ○DSI

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:_____

Has the student been referred to the Threat Assessment Team? ○**Yes** ○**No** If yes, date referred to TAT:_____

Is this student receiving services from another agency? ○**Yes** ○**No** If yes, DO NOT submit referral, student is ineligible for FSS

REFERRAL SOURCE:

- ☐ Self-referral by Parent/Guardian
- ☐ Self-referral by Student
- ☐ Threat Assessment Team
- ☐ Referred by Other

PARENT/GUARDIAN CONTACT:

Name:_____

Relationship to Student:_____

Telephone:_____

Email:_____

***If student is over 18, provide student contact info**

FORM COMPLETED BY:

Name:_____

Title/Position:_____

Telephone/Fax:_____

Email:_____

STUDENT ASSESSMENT:

BEHAVIOR CONCERNS:

- ☐ Disruptive
- ☐ Defiant
- ☐ Skipping
- ☐ Inappropriate Responses
- ☐ Excessive Absenteeism
- ☐ Sleeping in Class
- ☐ 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- ☐ Withdrawn (loner)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
- ☐ Anxiety
- ☐ Gang/Occult Related Drawings/ Symbols and Affiliation
- ☐ Suspected Use, Possession, Distribution,or Sale of Tobacco, Alcohol, or Other Drugs

ACADEMIC PERFORMANCE:

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

PERSONAL/FAMILY/FRIEND ISSUES:

- ☐ Divorce/Separation
- ☐ Poor Relationships
- ☐ Grief/Loss
- ☐ Negative Influences
- ☐ Abuse/Neglect
- ☐ Low Self-Esteem
- ☐ Recently Moved to the Area
- ☐ Human Trafficking

SERVICE REQUESTED (SELECT ONE):

- ○ Individual Counseling
- ○ Group Counseling
- ○ Health/Wellness.

Explain:_____

EVENT THAT INITIATED THE ASSESSMENT (REQUIRED):

_____

_____

_____

FOR FSS SOCIAL WORKER USE ONLY: Date of assessment:_____ Comments:_____

FOR FSS THERAPIST USE ONLY: Date of initiation of services:_____ Comments:_____