# 2023-24 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 SCHOOL USE ONLY*: PARENT/LEGAL GUARDIAN MUST BE NOTIFIED AND CONSENT TO REFERRAL PRIOR TO STUDENT BEING REFERRED FOR SERVICES**

Has a Tier 1 and Tier 2 behavioral intervention been implemented ? ◯ **Yes** ◯ **No** If **no, DO NOT submit referral, until this step is complete**

Please list Tier 1 and Tier 2 intervention:_____

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

Has the student been referred to the Threat Management 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.**

## PARENT/GUARDIAN CONTACT:

Name:_____

Relationship to Student:_____

Telephone:_____

Email:_____

*If student is 18 and older, provide student contact info

## FORM COMPLETED BY:

◯ Parent/Guardian ◯ Student ◯ Other ◯ Threat Management Team

Name:_____

Title/Position:_____

Telephone/Fax:_____

Email:_____

## STUDENT ASSESSMENT:

### BEHAVIOR CONCERNS:

- ☐ Disruptive
- ☐ Defiant
- ☐ Inappropriate Responses
- ☐ 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- ☐ Withdrawn (loner)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
- ☐ Human Trafficking

### SERVICE REQUESTED (SELECT ONE):

- ◯ Individual Counseling
- ◯ Group Counseling
- ◯ Health/Wellness

Explain:_____

### EVENT THAT INITIATED THE ASSESSMENT (REQUIRED):

_____

_____

_____

**FOR FSS SOCAL WORKER USE ONLY:** Date of assessment :_____ Comments:_____

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