



2025-26 FULL SERVICE SCHOOLS ASSESSMENT FOR SERVICES



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

Have tiered behavioral interventions been implemented? Yes No If no, DO NOT submit referral, until this step is complete

Please list two tiered interventions: _____

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

Does that student have a mental health diagnosis? Yes No

Does the student have a history of trauma? Yes No

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- Disruptive, Defiant, Inappropriate Responses, Sleeping in Class, Negative attitude, Self-Harm Behaviors, Mood Swings, Withdrawn (loner), Depressed mood (sad), Extreme weight loss/gain, Poor Social Skills, Anger, Bullying, Physical aggression, Anxiety, Homicidal Thoughts, Suicidal Thoughts, History of Baker Acts, 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, Low Self Esteem, Abuse/Neglect, Human Trafficking, Attendance Issues

SERVICE REQUESTED (SELECT ONE):

- Individual Counseling, Group Counseling, Health/Wellness, Hazel Heart (Teletherapy)

School Counselor MUST Complete Hazel Heart referral

EVENT THAT INITIATED THE ASSESSMENT AND/OR MENTAL HEALTH DIAGNOSIS, TRAUMA HISTORY (REQUIRED):

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

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