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 <u>and</u> 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- ◯ Withdrawn (loner)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

PERSONAL/FAMILY/FRIEND ISSUES:

- ◯ 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):

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____

____

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:_______________________________