



**1601 R Avenue
Anacortes, WA 98221**
Mental Health Services
Office Telephone: 360-299-4017
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Child Behavioral Health Services Referral Form

Student Name: _____ **Gender:** _____
DOB: _____ **Age:** _____ **Grade:** _____
School District: _____ **School:** _____
Teacher: _____ **Phone #:** _____
School Counselor: _____ **Phone #:** _____
Parent/Legal Guardian Name: _____
Relationship to Student/Client: _____
Address: _____
Home Phone: _____ **Cell/Other Phone:** _____
Is Child's Primary Language English: Yes No
Child's Other Language(s): _____ **Other Language(s) Spoken in Home:** _____

DEMOGRAPHICS AND REFERRAL

Ethnicity: (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Latino/Hispanic | <input type="checkbox"/> Caucasian/White |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> American Indian | <input type="checkbox"/> Russian/Ukrainian |
| <input type="checkbox"/> Other (Specify): _____ | | |

Living Situation: (check one)

- | | | |
|--|--|---|
| <input type="checkbox"/> Both parents | <input type="checkbox"/> Foster Care | <input type="checkbox"/> Partnered Adults |
| <input type="checkbox"/> Parent and Stepparent | <input type="checkbox"/> Alone or with Friends | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Single Parent | <input type="checkbox"/> Other Out of Home Placement | |
| <input type="checkbox"/> Relatives | <input type="checkbox"/> Other (Specify): _____ | |

Participating in Special Program: (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> English Language Learner (ELL) | <input type="checkbox"/> Local Program | <input type="checkbox"/> Head Start/Early Head Start |
| <input type="checkbox"/> Special Education | <input type="checkbox"/> McKinney-Vento | <input type="checkbox"/> Free/Reduced Lunch |
| <input type="checkbox"/> Title I or Learning Assistance
Program (LAP) | <input type="checkbox"/> 504 | <input type="checkbox"/> Migrant |
| | <input type="checkbox"/> Gifted | <input type="checkbox"/> Other (Specify): _____ |

Reason(s) for Referral: (one or more must be checked)

- | | | |
|---|---|---|
| <input type="checkbox"/> Poor Attendance | <input type="checkbox"/> Low Interest in School | <input type="checkbox"/> Early Intervention |
| <input type="checkbox"/> Academic Problems | <input type="checkbox"/> Developmental Delay | (must have at least one
additional reason below) |
| <input type="checkbox"/> School Behavior Problems | <input type="checkbox"/> Kindergarten Readiness | |

Additional Reasons: (check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Limited English Proficiency | <input type="checkbox"/> Family Basic Needs | <input type="checkbox"/> Homeless |
| <input type="checkbox"/> Health Needs for Child | <input type="checkbox"/> Family Violence | <input type="checkbox"/> Substance Abuse Issues |
| <input type="checkbox"/> Reported Physical/Sexual Abuse | <input type="checkbox"/> At Risk of Being Homeless | <input type="checkbox"/> Developmental Concerns |
| <input type="checkbox"/> Mental Health Needs | <input type="checkbox"/> Other (Specify): _____ | |

NEEDS ASSESSMENT

Social/Emotional: (check all that apply) **or**

- | | |
|--|--|
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> No Identified Need in this Area |
| <input type="checkbox"/> Parenting | <input type="checkbox"/> Family Violence |
| <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Other Mental Health Concerns |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Physical Abuse/Sexual Abuse/Neglect |
| | <input type="checkbox"/> Other – Please Describe: _____ |

Cultural Factors: (check all that apply) **or**

- | | |
|--|---|
| <input type="checkbox"/> Language | <input type="checkbox"/> No Identified Need in this Area |
| <input type="checkbox"/> Literacy | <input type="checkbox"/> Family Customs/Beliefs |
| <input type="checkbox"/> Communication with School/Other Professionals | <input type="checkbox"/> Cultural Approach to Help-Seeking/Acceptance |
| <input type="checkbox"/> Other – Please Describe: _____ | |

GLE TEACHER RATING FORM - INTIAL

Utilizing the Grade Level Expectations (GLEs) for this child’s current grade placement, please check the appropriate box for EACH of the outcomes below.

For assistance with the GLEs, please consult: <http://www.k12.wa.us/ealrs/default.aspx>

Mathematics	Below Standard	Meets Standard	Not Observed
1. The student understands and applies the concepts and procedures of mathematics:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The student uses mathematics to define and solve problems:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The student mathematical reasoning:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The student communicates knowledge and understanding in both everyday and mathematical language:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The student understands how mathematical ideas connect within mathematics, to other subject areas, and to real-life situations:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading	Below Standard	Meets Standard	Not Observed
1. The student understands and uses different skills and strategies to read:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The student understands the meaning of what is read:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The student reads different materials for a variety of purposes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The student sets goals and evaluates progress to improve reading:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Attendance (past 90 days)

Number of Excused Absences: _____ **Number of Unexcused Absences:** _____

Number of Times Tardy: _____

Comments: _____

Discipline (past 90 days)

Number of Suspensions: _____ **Number of Expulsions:** _____

Number of Discipline Referrals: _____

Comments: _____

Reason for Referral: Please briefly state Behavioral, Family, Social, Emotional, Academic and other concerns/needs. Include other services Child/Family Currently Receiving (e.g. IEP, 504, DSHS): _____

Desired Outcome(s): _____

Parent/Guardian contacted regarding this referral? Yes No

Informed Consent Form completed and attached? Yes No

Insurance information: Medicaid Private Insurance None Unknown

Name, contact information, signature of referent:

Referent's Signature

Date

Referent's Agency

Referent's Printed Name

Referent's Phone Number