Northwest Educational Service District 189
Together We Can

1601 R Avenue
Anacortes, WA 98221
Behavioral Health Services
Office Telephone: 360-299-4017
Office FAX: 360-299-4005

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)

☐ Asian/Pacific Islander
☐ Black/African American
☐ Other (Specify): _____
☐ Latino/Hispanic
☐ American Indian
☐ Caucasian/White
☐ Russian/Ukranian

Living Situation: (check one)

☐ Both parents
☐ Parent and Stepparent
☐ Single Parent
☐ Relatives
☐ Foster Care
☐ Alone or with Friends
☐ Other Out of Home Placement
☐ Other (Specify): _____
☐ Partnered Adults
☐ Unknown

Participating in Special Program: (check all that apply)

☐ English Language Learner (ELL)
☐ Special Education
☐ Title I or Learning Assistance Program (LAP)
☐ Local Program
☐ McKinney-Vento
☐ 504
☐ Gifted
☐ Head Start/Early Head Start
☐ Free/Reduced Lunch
☐ Migrant
☐ Other (Specify): _____

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

☐ Poor Attendance
☐ Academic Problems
☐ School Behavior Problems
☐ Low Interest in School
☐ Developmental Delay
☐ Kindergarten Readiness
☐ Early Intervention (must have at least one additional reason below)

Additional Reasons: (check all that apply)

☐ Limited English Proficiency ☐ Family Basic Needs ☐ Homeless
☐ Health Needs for Child ☐ Family Violence ☐ Substance Abuse Issues
☐ Reported Physical/Sexual Abuse ☐ At Risk of Being Homeless ☐ Developmental Concerns
☐ Mental Health Needs ☐ Other (Specify): _____

NEEDS ASSESSMENT

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

☐ *No Identified Need in this Area*
☐ Behavioral Problems
☐ Parenting
☐ Emotional Problems
☐ Substance Abuse
☐ Family Violence
☐ Other Mental Health Concerns
☐ Physical Abuse/Sexual Abuse/Neglect
☐ Other – Please Describe: _____

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

☐ *No Identified Need in this Area*
☐ Language
☐ Literacy
☐ Communication with School/Other Professionals
☐ Family Customs/Beliefs
☐ Cultural Approach to Help-Seeking/Acceptance
☐ 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:	☐	☐	☐
2. The student uses mathematics to define and solve problems:	☐	☐	☐
3. The student mathematical reasoning:	☐	☐	☐
4. The student communicates knowledge and understanding in both everyday and mathematical language:	☐	☐	☐
5. The student understands how mathematical ideas connect within mathematics, to other subject areas, and to real-life situations:	☐	☐	☐
Reading	**Below Standard**	**Meets Standard**	**Not Observed**
1. The student understands and uses different skills and strategies to read:	☐	☐	☐
2. The student understands the meaning of what is read:	☐	☐	☐
3. The student reads different materials for a variety of purposes:	☐	☐	☐
4. The student sets goals and evaluates progress to improve reading:	☐	☐	☐

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**

Note: This program is for those who <u>are not</u> Medicaid or Insurance eligible. If this student/client is eligible for Medicaid or Insurance, describe barriers to service or other special needs in the "Other Information" section below.

Other information: _____

_____

Name, contact information, signature of referent:

_____ _____

Referent's Signature Date Referent's Agency

_____ _____

Referent's Printed Name Referent's Phone Number