



## Parent or Guardian Referral Form

Date: \_\_\_\_\_

Name of child: \_\_\_\_\_

Your name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

The school's care team may wish to contact you to discuss your referral concerns. Please provide your contact information and the best time to reach you.

Phone: \_\_\_\_\_ Best time to contact: \_\_\_\_\_

Who does your child live with?

- |   |  |
|---|--|
| <input type="checkbox"/> Biological parents | <input type="checkbox"/> Relative care |
| <input type="checkbox"/> Adoptive parents   | <input type="checkbox"/> Group home    |
| <input type="checkbox"/> Foster parents     | <input type="checkbox"/> Other: _____  |

Desired language of service?

- English  
 Spanish  
 Other: \_\_\_\_\_

Does your child have an individualized education plan (IEP)?

- Yes  
 No  
 I don't know

Area of concern (please describe):

- |   |  |
|---|--|
| <input type="checkbox"/> Academic Concerns:   | <input type="checkbox"/> Physical Health Concerns: |
| <input type="checkbox"/> Behavioral Concerns: | <input type="checkbox"/> Family Concerns:          |
| <input type="checkbox"/> Social Concerns:     | <input type="checkbox"/> Other: _____              |
| <input type="checkbox"/> Emotional Concerns:  |  |

Behavioral concerns (please mark all boxes that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Exposed to community violence, other trauma | <input type="checkbox"/> Talks excessively                     |
| <input type="checkbox"/> Nightmares, intrusive thoughts              | <input type="checkbox"/> Gets out of seat and moves constantly |
| <input type="checkbox"/> Anxious, fearful or irritable mood          | <input type="checkbox"/> Interrupts and blurts out responses   |
| <input type="checkbox"/> Jumpy or easily startled                    | <input type="checkbox"/> Inattentive, distractible, forgetful  |
| <input type="checkbox"/> Avoids reminders of trauma                  | <input type="checkbox"/> Disorganized, makes careless mistakes |
| <input type="checkbox"/> Aggressive                                  | <input type="checkbox"/> Angry towards others, blames others   |
| <input type="checkbox"/> Sexualized play or behaviors                | <input type="checkbox"/> Fights and is aggressive              |
| <input type="checkbox"/> Difficulty concentrating                    | <input type="checkbox"/> Argumentative and defiant             |

- |  |  |
|--|--|
| <input type="checkbox"/> Sad, depressed or irritable mood          | <input type="checkbox"/> Anxious and fearful       |
| <input type="checkbox"/> Hopelessness, negative view of future     | <input type="checkbox"/> Worries excessively       |
| <input type="checkbox"/> Low self-esteem, negative self-statements | <input type="checkbox"/> Difficulty sleeping       |
| <input type="checkbox"/> Difficulty concentrating                  | <input type="checkbox"/> Restless and on edge      |
| <input type="checkbox"/> Diminished interest in activities         | <input type="checkbox"/> Specific fears or phobias |
| <input type="checkbox"/> Low or decreased motivation               | <input type="checkbox"/> Difficulty concentrating  |
|  | <input type="checkbox"/> Clingy behavior           |
|  | <input type="checkbox"/> Appears distracted        |

How often is this behavior occurring? (e.g., several times per day; 1-2 times per week)

How long have you had this concern about your child?

To your knowledge, has your child ever received any supports or interventions for this behavior in the past?

To your knowledge, is your child receiving any supports or interventions for this behavior currently?

What do you think will help your child experience success?