Willamette
EDUCATION SERVICE DISTRICT

The Phoenix School
REFERRAL FORM

Please fax or scan completed form to Jack Fields
Jack.Fields@wesd.org

For questions please contact:
Jack Fields at 503-435-5903

Phoenix I - Please check the grade level needed:

☐ **Elementary (Grades 1-6)** ☐ **Middle School (Grades 7, 8)** ☐ **High School (Grades 9-12)**

Phoenix **II** ☐ **Grades K-5**

Billing Information:

☐ **District currently owns an open slot** ☐ **District will Purchase an additional slot**

Please Note: Slots for the program are purchased per student as full day slots for the entire school year

Name:_____ Grade: _____ Date of Birth:_____

SSID:_____

Date of Referral: _____ Home School: _____

Current Program: _____ Special Education Director:_____

Current School: _____ Phone:_____

Teacher:_____ Phone:_____

Parent/Guardian: _____ Person Referring/email:_____

Address:_____

Home Ph #:_____ Work Ph #:_____ Cell Ph #:_____

DHS Caseworker:_____ Phone:_____

Other Provider name and contact information: _____

Is student currently taking medication? ☐ Yes ☐ No If Yes, name of medication: _____

HMP ☐ Yes ☐ No

Allergies or other special health concerns:

Case Manager Responsible for IEP:_____

Date of most recent IEP:_____ Date of last reevaluation:_____

Primary Disability: _____ Secondary Disability: _____

Academic Grade Level:_____ Reading:___ Math:_____ Writing:____ Spelling:_____

Related Services:

SLP:_____ email:_____

OT:_____ email:_____

PT:_____ email:_____

ASD:_____ email:_____

AAC:_____ email:_____

Audiology:_____ email:_____

Behavorial Needs

Total suspensions this year: _____

Threat Assessment: ☐ Yes Date:_____ ☐ No

Level ☐ 1 ☐ 2

SIRC: ☐ Yes Date: _____ ☐ No

Level ☐ 1 ☐ 2

Suicide Risk Assessment: ☐ Yes Date:_____ ☐ No

Level ☐ 1 ☐ 2

Outside Services:

☐ Wrap Team ☐ Mental Health/Counceling

☐ Private ABA/OT/SLP… ☐ DD Services

☐ Juvenile Involvement ☐ Other:_____

PO Name:_____

Phoenix II Referral Only

Communication:

Does the student use a communication device? ☐ Yes ☐ No

If yes, what is the device and communication program? _____

☐ School Owned ☐ Private

Is the student working on toileting? ☐ Yes ☐ No

Feeding Protocol ☐ Yes ☐ No

Are there physical limitations/needs? ☐ Yes ☐ No

Transportation Needs

Does the student currently have specialized transportation? ☐ Yes ☐ No

Do they need a rider or specific accommodations (i.e. harness, seatbelt lock, etc.)

☐ Yes Describe:_____

☐ No

Current Environmental Setting

☐ Specialized Classroom

Describe (# of students, staff, etc..) _____

☐ Gen ed w/ pull out or push in support

Describe _____

☐ Personal Learning Setting (i.e. primarily in 1:1 learning)

Describe _____

☐ Needs 1:1 Support

Describe (what settings, what activities…) _____

Please attach the following to the completed form:

☐ Release of information form for TPS with parent.

☐ Copy of Current IEP/Placement

☐ Copy of Special Education Eligibility Statement and Psycho Educational Report

☐ Copy of Functional Behavioral Assessment/Behavior Support Plan /Safety Plan

☐ Copy of Psychological Report, Clinical Psychological and/or Psychiatric Reports

☐ Copy of all available academic assessments and/or scores

☐ Medication/medical protocol, if applicable (included HMP)

☐ Transcripts

☐ Immunization Records

☐ IEP progress reports

☐ Behavioral Data (classroom)

Desired Goal/Outcomes with Referral to TPS:

Top 3 areas of desired skill accuisition

1) _____

2) _____

3) _____

Signature of Sending School Staff who is responsible for informing family

Sign Here: _____ Date: _____