



Behavioral Health Department

Student Name: _____

Date of Request: _____

Please choose all appropriate services, fill in necessary information and include requested documentation. To assist Monroe One in fulfilling your request, please indicate the reason for referral and any additional information that will help us provide services:

Direct Counseling Services (with direct services, counseling consultation is also recommended):

Individual or Group	Frequency (number of sessions, recommended weekly)	Duration (minutes per session, 30 minutes recommended)	Ratio for Group services

Consultations

Counseling Consultation Frequency (number of hours per year):

Behavior Specialist Consultation Frequency (number of hours per year):

Psycho-Educational Evaluations *(By sending the request, Monroe One assumes consent has been received)*

Initial Evaluation

Comprehensive Re-Evaluation (Cognitive and Achievement testing)

Specific Area (Cognitive or Achievement or Social/Emotional)

Bi-lingual: Yes No If yes, what language?

Reason for Evaluation(s):

CSE Date/Time or indicate if not scheduled:

Functional Behavioral Assessment (FBA)

Family Life Education and Counseling Service (FLECS) Hours Requested:

*The minimum for a new referral is 5 hours and then additional hours may be recommended

Type of Education (please select one):

School Contact Name:

Contact Information:

Documentation Requested for All Services (if available):

- IEP (services must match the request)
- Current/Pertinent Reports from other domains
- Current Psychological Evaluation
- Cross Contract (if a non-component district)

Send cover sheet, request forms, and requested documentation to itinerant@boces.monroe.edu

OFFICE OF SPECIAL EDUCATION AND STUDENT SERVICES