

# SCHOOL REFERRAL FORM

## REFERRING PERSON

|            |               |
|------------|---------------|
| Full Name: | Phone Number: |
| Date:      | Email:        |

## PARTICIPANT INFORMATION

|                  |                             |
|------------------|-----------------------------|
| Full Name:       | Primary Language:           |
| Address:         | City/Zip:                   |
| Birthdate & Age: | Social Security (optional): |

• Does child have Health Insurance? ☐ Yes ☐ No      If yes, what type: \_\_\_\_\_  
 • Any medical concerns? ☐ Yes ☐ No      (If yes, please specify) \_\_\_\_\_

|                                                        |                                                                                                            |
|--------------------------------------------------------|------------------------------------------------------------------------------------------------------------|
| Current School:                                        | Grade:                                                                                                     |
| School Contact #:                                      | Education Support: <input type="checkbox"/> IEP <input type="checkbox"/> 504 <input type="checkbox"/> None |
| Student's Strengths:                                   |                                                                                                            |
| Reason for Referral- home, school, and other concerns: |                                                                                                            |

## CONSENT

I consent to allow school personnel to refer my child \_\_\_\_\_ for services provided by the School Based Early Intervention program (SBEI) and/or School Based Outpatient Program (SBOP). I understand that relevant information may be provided to them, such as name, address, phone number, attendance records, discipline, and grades. If my child is receiving Special Education services, I give consent to have a copy of the most recent 504 plan or Individual Education Plan (IEP) given to the selected service provider. I have received aftercare instructions and recognize the significance of adhering to them to preserve the results and prevent any possible complications. If the referral is initiated by SBEI/SBOP staff, I provide authorization for RCS to disclose to the School/School District a copy of the referral and coordinate treatment.

Parent Guardian Signature: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_

|                       |                    |
|-----------------------|--------------------|
| Parent/Guardian name: | Best time to call: |
|-----------------------|--------------------|

### RCS Use Only

☐ SBOP    ☐ Families First

SSID #:

Date Referral Received: