**Appendix A: Example Referral Forms**

**Staff Member Referral Form**

|  |  |  |  |
| --- | --- | --- | --- |
| Student Name: |  | Grade: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Your Name: |  | Relationship: |  |

Members of the school problem-solving team may reach out to you to gather more information. Please provide your contact information.

|  |  |  |  |
| --- | --- | --- | --- |
| Phone #: |  | Email: |  |

|  |  |
| --- | --- |
| Best time to contact you: |  |

**About the Student**

|  |
| --- |
| Student Strengths: |
|  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Does the student have an IEP? |  | Yes |  | No |  | Unsure |

**Areas of Concern:** (Please check all that apply)

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Academic |  | Behavioral |  | Emotional |  | Family |  | Social |  | Other |

|  |
| --- |
| Please Explain: |
|  |

|  |
| --- |
| How long has this been occurring? (Several months, a few days, etc.) |
|  |

**What are you noticing about the student?** (Please check all that apply)

|  |  |
| --- | --- |
| * Anxious/fearful
* Appears distracted
* Clinging to adults
* Difficulty sleeping
* Difficulty concentrating
* Excessive worry
* Restless/appears to be on edge
* Specific fears/phobias
* Aggressive
* Avoids reminders of trauma
* Exposed to community violence
* Irritable/anxious mood
* Jumpy/hypervigilant
* Nightmares/intrusive thoughts
* Sexualized play
 | * Decreased motivation
* Depressed/sad/irritable mood
* Hopelessness/ negative view of future
* Loss of interest in activities student once enjoyed
* Low self-esteem
* Angry towards others/blames others
* Argumentative
* Constantly moving
* Defiant
* Disorganized
* Inattentive/distractible
* Interrupts/blurts out responses
* Physically aggressive
 |

|  |
| --- |
| How often do these behaviors occur? (several times per day, once per week, etc) |
|  |

|  |
| --- |
| What interventions have been tried? Were they helpful? |
| School:Home: |

|  |
| --- |
| What interventions are currently in place? |
| School:Home: |

|  |
| --- |
| What do you think would be helpful to the student? |
|  |

**Parent/Guardian/Family Member Referral Form**

|  |  |  |  |
| --- | --- | --- | --- |
| Student Name: |  | Grade: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Your Name: |  | Relationship: |  |

Members of the school problem-solving team may reach out to you to gather more information. Please provide your contact information.

|  |  |  |  |
| --- | --- | --- | --- |
| Phone #: |  | Email: |  |

|  |  |
| --- | --- |
| Best time to contact you: |  |

**About Your Child**

|  |
| --- |
| Child’s Strengths: |
|  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Does your child have an IEP? |  | Yes |  | No |  | Unsure |

**Areas of Concern:** (Please check all that apply)

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Academic |  | Behavioral |  | Emotional |  | Family |  | Social |  | Other |

|  |
| --- |
| Please Explain: |
|  |

|  |
| --- |
| How long has this been occurring? (Several months, a few days, etc.) |
|  |

**What are you noticing about your child?** (Please check all that apply)

|  |  |
| --- | --- |
| * Anxious/fearful
* Appears distracted
* Clinging to adults
* Difficulty sleeping
* Difficulty concentrating
* Excessive worry
* Restless/appears to be on edge
* Specific fears/phobias
* Aggressive
* Avoids reminders of trauma
* Exposed to community violence
* Irritable/anxious mood
* Jumpy/hypervigilant
* Nightmares/intrusive thoughts
* Sexualized play
 | * Decreased motivation
* Depressed/sad/irritable mood
* Hopelessness/ negative view of future
* Loss of interest in activities student once enjoyed
* Low self-esteem
* Angry towards others/blames others
* Argumentative
* Constantly moving
* Defiant
* Disorganized
* Inattentive/distractible
* Interrupts/blurts out responses
* Physically aggressive
 |

|  |
| --- |
| How often do these behaviors occur? (several times per day, once per week, etc) |
|  |

|  |
| --- |
| Are there any supports or interventions that your child has received in the past? |
|  |

|  |
| --- |
| What supports or interventions is your child currently receiving? |
|  |

|  |
| --- |
| What do you think would be most helpful for your child? |
|  |

**Student Referral Form: Self or Peer**

|  |  |  |  |
| --- | --- | --- | --- |
| Your Name: |  | Grade: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Who are you looking for support for? |  | Myself |   | A peer |

|  |  |
| --- | --- |
| Name of Peer: |  |

Members of the school problem-solving team may reach out to you to gather more information. May we contact you?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes it’s ok to contact me about my concern |   | No, please don’t contact me |

**What are you noticing that concerns you?** (Please check all that apply)

|  |  |
| --- | --- |
| * Anxious/fearful
* Appears distracted
* Clinging to adults
* Difficulty sleeping
* Difficulty concentrating
* Excessive worry
* Restless/appears to be on edge
* Specific fears/phobias
* Aggressive
* Avoids reminders of trauma
* Exposed to community violence
* Irritable/anxious mood
* Jumpy/hypervigilant
* Nightmares/intrusive thoughts
 | * Decreased motivation
* Depressed/sad/irritable mood
* Hopelessness/ negative view of future
* Loss of interest in activities student once enjoyed
* Low self-esteem
* Angry towards others/blames others
* Argumentative
* Constantly moving
* Defiant
* Disorganized
* Inattentive/distractible
* Interrupts/blurts out responses
* Physically aggressive
 |

|  |
| --- |
| How often do these behaviors occur? (several times per day, once per week, etc) |
|  |

|  |
| --- |
| What else would you like us to know? |
|  |