FULL SERVICE SCHOOLS
REFERRAL FOR SERVICE(S)

Referral Date:__________.

Student Name: ________________Student Number: _____________ School: ________________

Grade Level: _____ Age: _____D.O.B.: _________ Gender: __________Race/Ethnicity: ________

Address:____Zip Code: ___________

Classroom/Homeroom Teacher:___________________ ESE Designation: _________________

For DCPS Staff Use Only: PARENT/LEGAL GUARDIAN MUST BE NOTIFIED AND CONSENT TO REFERRAL PRIOR TO STUDENT BEING REFERRED FOR SERVICES**

Parent/Legal Guardian Notified of Referral? ◯ **Yes** ◯ **No** Parent/Legal Guardian Provided Consent for Referral? ◯ **Yes** ◯ **No**

Consenting Parent/Legal Guardian Name:________________________________Date of Consent for Referral:____________

Please mark the following area(s) of concern/services needed and explain in the comment section:

CLASSROOM CONDUCT:

◯ Disruptive/Defiant
◯ Skipping
◯ Inappropriate Responses
◯ Excessive Absenteeism
◯ Sleeping in Class

BEHAVIOR(S) OBSERVED:

◯ Negative attitude
◯ Self-Harm Behaviors
◯ Mood Swings
◯ Suicidal/Homicidal Thoughts
◯ Withdrawn (loner)
◯ Extreme weight loss/gain
◯ Poor Social Skills
◯ Anger
◯ Bullying
◯ Physical aggression
◯ Difficulty Accepting mistakes
◯ Gang/Occult Related Affiliation
Defensiveness
Depressed mood (sad)

ACADEMIC PERFORMANCE:

Declining Quality of Work
Academic Failure
Lack of Motivation
Unrealistic expectations
Lack of Concentration/Attention Focus

PERSONAL/FAMILY/FRIEND ISSUES:

Divorce/Separation
Poor Relationships
Grief/Loss Negative
Influences Abuse/
Neglect
Low Self-Esteem Recently
Moved to the Area Sexual
Identity/Orientation
(Struggles/Self Referrals)

ALCOHOL/DRUG USE:

◯ Suspected Use, Possession, Distribution, or Sale of Tobacco, Alcohol, or Other Drugs

HEALTH & WELLNESS SERVICE NEED:

Individual Counseling
Group Counseling
Mentoring
Teen Parent Services
Medical
Food
Vision
Clothing

Is the student receiving services from another agency? Yes No

If yes, list agencies and contact names (if known):

Event(s) that occurred that initiated the FSS Referral (REQUIRED)

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FOR FSS SOCIAL WORKER USE ONLY: Date of assessment:

FOR FSS THERAPIST USE ONLY: Date services initiated:

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REFERRAL SOURCE:

Self-referral by Parent/Guardian
Self-Referral by Student
Referred by Other

PARENT/GUARDIAN CONTACT:

Name:______________________________
Relationship to Student:________________
Telephone:__________________________
Email:_____________________________

FORM COMPLETED BY:

Name:______________________________
Title/Position:_______________________
Telephone/Fax:______________________
Email:_____________________________