Date:

**STUDENT INFORMATION:**

Name:

Male / Female / Other Race:

DOB:

Age:

Grade:

IEP Ruling/Services (if applicable):

**PARENT/LEGAL GUARDIAN INFORMATION:**

Parent/Legal Guardian Name: Relationship: Phone: Address:

Parent/Legal Guardian Name: Relationship: Phone: Address:

**SCHOOL INFORMATION:**

Name: Homeroom Teacher:

**REASONS FOR REFERRAL: *(Circle ALL that apply and write a brief description)***

Behavioral Social Emotional

**CONCERNS/PROBLEMS: *(Please CIRCLE ALL that apply)***

Abuse:

Emotional/Physical/Verbal/Sexual/Neglect\* Anger:

Aggressive/Argues Often/Frequent

Fights/Often angry/Loses Temper Easily Anxiety, Nervousness

Behavior Problems

Bullying, Harassment (by or to others) Chronic Absenteeism

Compulsive Behaviors Concentration:

Fails to finish tasks/Difficulty focusing

Defiant/Oppositional Depression:

Sadness/Cries Often Destroys Property Disrespectful Disruptive in Class Does Not Sit Still

Frequent Temper Tantrums Frequently Sent to Office:

Multiple School Suspensions Hallucinations:

Auditory/Visual

Impulsive

Lies Often

Mood Swings

Needs Testing

Picks Fights w/Peers Runs Away

Sexually Acting Out Talks Excessively Withdrawn

Other Concerns:

**ACTIONS ALREADY TAKEN BY SCHOOL: *(ISS, Alternative School, Referral to Tier 2 - document the timeline). List any behavioral intervention attempts and document the timeline.***

***\*As a Mandated Reporter, if you suspect he/she is being abused and/or neglected, it is your responsibility to report it to the Child Abuse Hotline at: 1-800-222-8000 or online at: https://reportabuse.mdcps.ms.gov/***

Staff Making Referral / Title

**SCHOOL STAFF RECEIVING REFERRAL:**

Name/Title: Date:

***\*Contact Parent/Legal Guardian PRIOR to sending referral\****

Contact Attempts:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of Parent/Legal Guardian** | **Relationship** | **Date** | **Time** | **Contacted? Yes or No** | **Consent? Yes or No** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Referral sent to , on

***(Mental Health Provider) (Date)***

by Fax: /Other:

***(Fax #)***

Signature