

SUMMIT PROGRAM REFERRAL FORM

2017 -18

This referral is for (please check the appropriate box):

- Summit School Program
 Therapeutic Day Program (TDP)

Date of Referral: ___/___/___ Referral Source: _____ Referral Source Contact Number: _____

Student Name: _____ ID #: _____ Home School: _____

Age: ___ Birthdate: ___/___/___ Male/Female: ___ Grade: ___ Home School Counselor: _____

Parent/Guardian: _____ Contact Number: _____

Address: _____ City: _____ Zip: _____

Interpreter needed when contacting parent: ___ Yes ___ No How would student be transported to Summit? _____

Medical Diagnosis: _____ Medications (please list): _____

ENRICH Program: ___ Yes ___ No (If yes, indicate program type below)

___ Individualized Education Plan (IEP)

___ English Speakers of Other Languages (ELDP)

___ District Individual Learning Plan (DILP)

___ Gifted & Talented –Advanced Learning Plan (ALP)

___ Multit-tiered System of Support (M.T.S.S.)/Response To Intervention (RTI) ___ Tier 1 ___ Tier 2 ___ Tier 3 ___

___ Section 504

Name of School Psychologist involved with this referral: _____

Name of Special Education Coordinator contacted by School Psychologist: _____ Date: _____

Name of Building Administrator involved with this referral: _____ Contact Number: _____

Primary behaviors to be addressed: _____

How does the family view this behavior? _____

Does this behavior occur at home or in other settings? Please describe: _____

Describe any past or current strategies or interventions to address these behaviors:

Would family be cooperative with treatment interventions? ___ Yes ___ No If no, please explain _____

Other relevant family information: _____

Current or Previous Involvement With:

Name of Agency and Contact:

___ Attendance-Truancy Plan	_____
___ Career Center/WCCC	_____
___ Day/Residential Treatment/Inpatient	_____
___ KNEX (Kids Needing Extra)	_____
___ ISST (Individual Supportive Services Team)	_____
___ Mind Springs Health	_____
___ Parole, Probation, Diversion, Tracking	_____
___ School Based Threat Assessment	_____
___ Social Services (e.g. Foster Care, voluntary case)	_____
___ Other (Private Therapy, ATU, RYS, Partners, Psychiatry)	_____

The following documentation (*if relevant*) is required and must be submitted with this referral:

- Current IEP (Most recent eligibility IEP and most current, if different)
- Current FBA/RtI Instructional Decision-Making Plan (Optional) Form H-2 Step 4 Evaluation Data
- Current Behavior Intervention Plan (BIP) with current corresponding data
- School Readiness Checklist
- Discipline reports for past 12 months (from Synergy)
- Transcripts
- Copies of parent provided professional reports (e.g. Private Therapists, Discharge Summaries, etc.)
- Signed releases to any outside agencies
- Signed Release for Mind Springs for District 51 (see attached)

Note: The School Psychologist should bring this form and all required supporting documentation when meeting with their Special Education Coordinator to inform them of the referral.