



Parent/Guardian Referral Form

Date: _____ Name of child: _____

Your name: _____ Relationship to child: _____

The School's care team may wish to contact you to discuss your referral concerns. Please provide your contact information.

Phone: _____ Best time to contact: _____

Who does your child live with?

- Biological parents
- Adoptive parents
- Foster parents
- Relative
- Group Home
- Other: _____

Desired language of service?

- English
- Spanish
- Other: _____

Does your child have an individualized education plan plan (IEP)?

- Yes
- No
- I don't know

Areas of concern:

- Behavioral Concerns
- Social Concerns
- Physical Health Concerns
- Family Concerns
- Other: _____

Date Received by School Staff:	Initials:
Date received by Mental Health Navigator:	Initials:



Check all that apply with child:

<ul style="list-style-type: none"><input type="checkbox"/> Anxious/fearful<input type="checkbox"/> Appears distracted<input type="checkbox"/> Clinging to adults<input type="checkbox"/> Difficulty sleeping<input type="checkbox"/> Difficulty concentrating<input type="checkbox"/> Excessive worry<input type="checkbox"/> Restless/appears to be on edge<input type="checkbox"/> Specific fears/phobias <input type="checkbox"/> Aggressive<input type="checkbox"/> Avoids reminders of trauma<input type="checkbox"/> Exposed community violence<input type="checkbox"/> Irritable/anxious mood<input type="checkbox"/> Jumpy/hypervigilant<input type="checkbox"/> Nightmares/intrusive thoughts<input type="checkbox"/> Sexualized play	<ul style="list-style-type: none"><input type="checkbox"/> Decreased motivation<input type="checkbox"/> Depressed/sad/irritable mood<input type="checkbox"/> Hopelessness/negative view of future<input type="checkbox"/> Loss of interest in activities student once enjoyed<input type="checkbox"/> Low self-esteem <input type="checkbox"/> Angry towards others/blames others<input type="checkbox"/> Argumentative<input type="checkbox"/> Constantly moving<input type="checkbox"/> Defiant<input type="checkbox"/> Disorganized<input type="checkbox"/> Inattentive/distractible<input type="checkbox"/> Interrupts/blurts out responses<input type="checkbox"/> Physically aggressive
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How often is this behavior occurring? (e.g., several times per day; 1-2 times per week)

How long have you had this concern about your child?

To your knowledge, has your child ever received any supports or interventions for this behavior in the past?

To your knowledge, is your child receiving any supports or inventions for this behavior currently?

What do you think will help your child experience success?

