

CONFIDENTIAL YEP REFERRAL FORM

Referral Source/School Contact: _____ Date: _____

Please list the best time(s) during your day to discuss these concerns further:

Child's Name: _____ Grade: _____ DOB: _____

Is this child in Special Ed? (IEP or 504): _____

Child's Parent/Guardian: _____

Reason for Referral: Please check all that apply

- | | | |
|--|---|--|
| <input type="checkbox"/> Low or failing grades | <input type="checkbox"/> Disorganized | <input type="checkbox"/> Suspected drug/alcohol use |
| <input type="checkbox"/> Late or missing assignments | <input type="checkbox"/> Lethargic or sleepy | <input type="checkbox"/> Out of seat/fidgety |
| <input type="checkbox"/> Poor attendance or tardiness | <input type="checkbox"/> Inattentive or distracted | <input type="checkbox"/> Lies or cheats |
| <input type="checkbox"/> Hyperactive or impulsive | <input type="checkbox"/> Teases or Taunts others | <input type="checkbox"/> Atypical/Bizarre behavior |
| <input type="checkbox"/> Poor test/quiz performance | <input type="checkbox"/> Hygiene/poor self-care | <input type="checkbox"/> Talks out |
| <input type="checkbox"/> Lack of engagement or participation | <input type="checkbox"/> Physical complaints | <input type="checkbox"/> Steals |
| <input type="checkbox"/> Lack of motivation or apathy | <input type="checkbox"/> Inappropriate/older peer group | <input type="checkbox"/> Appears lonely or avoids others |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Suicidal | <input type="checkbox"/> Threatens/intimidates |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Withdrawn or Shy | <input type="checkbox"/> Defies Rules |
| <input type="checkbox"/> Sad or depressed | | <input type="checkbox"/> Disrespectful to adults |

Reason for the referral: (optional narrative)

Has the family been informed about YEP services? ___ Yes ___ No

If yes, please explain:

Thank you for your interest and concern about this student.

CONFIDENTIAL REFERRAL CONSIDERATIONS

Referral Considerations (please check all that apply)

- Student is at risk of self-harm or harm to others
- Student is transitioning from out-of-home or community based services
- Student meets the criteria for a serious emotional disturbance diagnosis
- Positive behavior interventions and supports have been tried but concerns continue
- Student is not attending school due to a mental health condition
- Student is transferring from other CSCT program

Other considerations:

Referral Accepted for CSCT Assessment Date: _____

Parent Contact Date and Response: _____

Referral Denied Date and Reason: _____

On Waiting List Date and Reason: _____

Referral Source/School Contact Signature: _____

Parent Signature: _____