Request for Behavioral Screening and/or Consultation

Student _____ School _____
Date of Birth _____ Grade _____
Parent(s) _____ Teacher _____
Home phone _____ Work phone _____ Other phone _____

Referred by:

☐ Student Assistance Team (SAT), ☐ 504 Team, ☐ IEP Team
Name of SAT, 504, or IEP Contact Person _____
☐ Parent
☐ Doctor (or other professional)
Name of referring professional _____

Reason for referral:

Outcome(s) expected as a result of the referral:

Check one of the following to Consent, Request Conference, or Deny Consent:

☐ I am aware of the above-listed reasons for my child's referral and **DO GIVE CONSENT** for screening and consultation completed by the ESU 10 School Psychologist.

☐ I am aware of the above-listed reasons for my child's referral but **WISH TO CONFERENCE** with a school representative and the ESU 10 school psychologist before giving or denying consent for screening and consultation. To schedule this conference, I can be reached at (list at least two options):

Day of the week _____ time _____ at phone number _____

Day of the week _____ time _____ at phone number _____

☐ I am aware of the above-listed reasons for my child's referral and **DO NOT GIVE CONSENT** at this time for screening and consultation completed by the ESU 10 School Psychologist.

Check the following to provide release of information:

☐ If one expected outcome of this referral is consultation with an outside service provider (for example, a doctor or therapist), I also **GIVE CONSENT FOR EXCHANGE OF INFORMATION** between the ESU 10 School Psychologist and the professional listed below:

Name_____
Address _____
_____
Phone _____ Fax _____

Parent Signature _____ Date _____

pf 5/2004