RCPS Behavioral Intervention Referral Form

To Be Completed By Referral Source or School Counselor

1. IDENTIFYING INFORMATION (Please complete boxes)

Referral date: Student's RCPS ID#:

Student name: Gender: ☐ Female ☐ Male _____ Ethnicity:

School: Grade: Birth date: Age:

Student address: Zip:

Parent/Guardian name(s):

Home phone: Cell phone: Work phone: _____

Custodial Rights: ☐ Mother ☐ Father ☐ Both ☐ Guardian ☐ State Agency ☐ Other _____

Does the student have a ***current*** IEP? ☐ Yes ☐ No

If yes, Case Manager name: _____ Consultant name: _____

Does the student have a Section 504 Plan? ☐ Yes ☐ No

Does the student and/or parent/guardian require an interpreter? ☐ Yes ☐ No Language: _____

2. REFERRAL INFORMATION

Who is making this referral? (Name)

Referrer is a: ☐ School Counselor ☐ Administrator ☐ School Social Worker
☐ Psychologist ☐ Other Parent

Referral source's phone #: Email:

To which school counselor is this student assigned? Phone #: _____ Email: _____

Has this student been staffed with your school's RTI/SST/AST? ☐ Yes ☐ No

Date case was staffed or will be staffed (if applicable): _____

In addition to this referral, please check any previous actions that have taken place in regard to this student.

☐ Individual Counseling	☐ Previous Hospitalization
☐ Group Counseling	☐ Drug Abuse Intervention
☐ Family Counseling	☐ Attendance Plan
☐ ISS	☐ Behavior Contract
☐ OSS	☐ Gang Contract
☐ CHOICES	☐ Current Medication
☐ Alpha Academy	☐ Behavioral Screening
☐ Fresh Start	☐ Evaluation
☐ DJJ	☐ P&I Specialist Involvement
☐ Probation	☐ Other Support Services

3. CONCERN (including self-report/peer reports)

Does this student exhibit any of the following warning signs for at-risk behaviors?

Early Warning Signs (low-to-medium-risk factors/behaviors)	
☐ Social withdrawal	☐ Intolerance for differences/prejudicial attitudes
☐ Poor social skills	☐ Low school interest/poor academic performance
☐ Excessive feelings of isolation and of being alone	☐ Excessive absences/Truancy
☐ Excessive feelings of rejection	☐ Affiliation with gangs
☐ Feelings of being picked on and persecuted	☐ Drug use and/or alcohol use
☐ Persistent sadness	☐ Expression of violence in writing and drawings
☐ Impulsive behavior	☐ Access to, possession of, and use of weapons
☐ Violent and/or aggressive behavior	☐ Recent loss, grief
☐ Uncontrolled anger	☐ Serious medical illness/traumatic injury
☐ Chronic disruptive behavior	☐ Legal Issues
☐ Bullying	☐ Family Issues
☐ Stealing	☐ Lying/Manipulative behavior
☐ Homeless	☐ Other

Imminent Warning Signs (high-risk factors/behaviors)	
☐ Serious physical fighting	☐ Setting fires
☐ Detailed threats of lethal violence	☐ Severe rage for seemingly minor reasons
☐ Possession and/or use of firearms, other weapons	☐ Sexually aggressive behavior
☐ Severe destruction of property	☐ Other self-injurious behaviors or threats of suicide
☐ Child Abuse & Neglect (CAN)	☐ Sexualized behaviors

What prompted this referral? What are your concerns about risk? Any additional comments you would like to include?

ITEMS 4 THROUGH 8 TO BE COMPLETED BY STAFF MEMBER MAKING REFERRAL.

4. PARENT/GUARDIAN/CUSTODIAL CONTACT

A. Has the family been notified that that a referral for behavioral interventions has been made? ☐ Yes ☐ No
B. Name of family member contacted:
C. Has family member signed Consent for Behavioral Health Screening and/or services? ☐ Yes ☐ No

5. OTHER PROFESSIONALS INVOLVED WITH STUDENT (for each yes, enter corresponding information below)

Child Welfare Services ☐ Yes ☐ No Juvenile Court ☐ Yes ☐ No

Mental Health Provider ☐ Yes ☐ No DJJ ☐ Yes ☐ No

Physical Health Provider ☐ Yes ☐ No Other _____

Name Agency Phone number

6. SERVICES RECOMMENDED/REFERED:

☐ Screening ☐ P&I Services ☐ SBMH Services ☐ CB MH/AD Services ☐ Counselor

Date referred **Date referred** **Date referred** **Date referred** **Date referred**

If School-Based MH Services recommended, who will contact AFE with referral information?

Name: Title: Phone Number:

7. My signature is acknowledgement that I have reviewed all of the information contained in this document.

Referrer's Signature: Date:

**** Please Sign and return to P&I Specialist for Processing/Data Entry.****

8. For Internal Use Only

☐ Initial P&I referral ☐ Repeat P&I referral ☐ Initial SBMH referral ☐ Repeat SBMH referral

☐ Initial Community-based referral ☐ Repeat Community-based referral

Referral Processed By: _____ Date: _____

P&I Specialist OR SBMH Therapist Assigned to Case: _____