

***Stark County Educational Service Center
Behavior Consultation
District Referral Form for Student Behavior Support Services***

This referral form is to be completed prior to the initial meeting with the Behavior Consultant. The referring professional will need to obtain the signature of the child's district of residence's Special Education Director before forwarding it to the Behavior Consultant. Completed referral forms can be mailed or faxed to: Cis Schumacher, SCESC, 2100 38th ST. NW, Canton, Ohio 44709: Fax: 330.493.1887. If you have further need of assistance, please contact Cis Schumacher, at 330.492.8136 EXT. 1451 or email:cis.schumacher@email.sparcc.org

Student Name: _____ DOB _____ Sex: ___M ___F

Grade/Placement: _____ School: _____ Phone: _____

Disability _____ If student has an Autism Spectrum Disorder (ASD) please use the Autism referral form on our website:

Current support services: Please Circle: S/L OT PT Personal Aid

District of Residence: _____ District of Attendance: _____

Teacher(s)/ _____ Email: _____

Parent(s) Name: _____

Parent(s) Address: _____

Parent's Phone: _____ Have parent(s) been contacted regarding this referral? ___Y ___N

Parent Permission for Review was signed ___Y ___N Form is available online at ESC website:

Please check the following services(s) you are requesting:

- Do a single observation and follow up with: (team contact person): phone/email _____
 - Do several observations and work with staff on developing behavior plan and positive supports.
 - Complete a Functional Behavior Assessment (FBA)
 - Re-evaluate a current Behavior Intervention Plan (BIP)
 - Help Team Develop a Behavior Intervention Plan (BIP)
 - Parent requests observation and consult
 - IEP Team requests Observation and consult
 - Other _____
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Please attach the following documents if available:

- Most recent ETR
- Most recent IEP
- Discipline history
- Behavior assessment or behavior plan, and data sheets of interventions you have tried.
- Signed parent permission to observe and review records. * Must have before first observation/consult.

Statement of the Problem (Why are you making the referral): _____

Give a brief description of one event that demonstrates the student's behavior in which they are being referred. Include what happened before the behavior occurred, what the behavior looked like and what were the consequences of the student's behavior (response of staff, peers etc.). _____

What specialized instruction and/or related services are currently provided? (list type & amount):

Are there significant factors about the student's strengths, learning style, coping strategies, or interests that the team should consider? _____

Is there any other significant information (medical, family, etc.) that the team should consider? _____

Contact Information:

The Behavior Consultant will contact the referring staff member for a team meeting when this form is received at the SCESC. Please note that it is the responsibility of the District contact person to invite all team members to any scheduled meetings that are a result of this request. Team members should include all service Providers and parent(s) if appropriate.

Referring Staff Member: _____ School _____

Phone# & email: _____ Email: _____

Date: _____
Signature of Referring Staff Person/ Date:

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* Signature of Special Education Director/Date

Office Use:

Date Returned _____ 1st visit scheduled _____

Comments

Sept. 2012 BI