Serendipity Center Referral Form

Thank you for your interest in Serendipity Center's therapeutic school program. We ask that you provide comprehensive information as a part of this process, so that we can conduct screenings that are both individualized and efficient. When we have received a completed application, we will contact you within one week to discuss the potential for a screening.

All fields must be completed in order for us to process a referral.

District Information

Date of referral: _____/_____/_____

Current school district: _____

District Representative: _____
(first) (last)

_____ _____
(email) (cell phone)

Student Information

Student name: _____
(first) (last)

Preferred pronouns: _____ Student DOB: _____/_____/_____

Student SSID: _____ Student district ID: _____

Current grade: _____

# of student suspension days used to date: _____

Student's current attendance rate: _____

Special education eligibility: _____

Educational surrogate: (if applicable) _____ (name) _____ (phone #)

Guardian Information

Primary Caregiver: _____
(first) (last)

Relationship to student: _____ Preferred pronouns: _____

Home address: _____

_____
(city) (state) (zip code)

_____ _____
(email) (cell phone)

_____
(work phone)

Preferred language: _____ Translator available? ☐ Yes ☐ No

Additional Involvement

Is the student in DHS custody? ☐ Yes ☐ No
*DHS workers should attend screenings

If yes, DHS Case Worker name: _____
(first) (last)

_____ _____
(email) (cell phone)

Is there active juvenile justice involvement? ☐ Yes ☐ No
*Court Counselor should attend either a screening or a status report meeting

If yes, Court Counselor name: _____
(first) (last)

_____ _____
(email) (cell phone)

Is the student a Medicaid recipient? ☐ Yes ☐ No

If yes, Medicaid ID #: _____

Current/previous school placements & approximate length of time at each (most recent first)	
Name of placement:	Approx. length of stay:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Please indicate areas of concern regarding this student:

☐ History of non-attendance	☐ Weapons	☐ Multiple school placements
☐ Academic deficits	☐ Self endangering behaviors	☐ School phobia
☐ Physical aggression	☐ Medication concerns	☐ Recent hospitalization
☐ Verbal aggression	☐ Home/family problems	☐ Recent discharge/ plan to discharge from residential/ other treatment setting
☐ Substance misuse (☐ student ☐ family)	☐ Gang affiliation/ high risk of gang affiliation	
☐ Difficulty with peers	☐ Sexual acting out	☐ Other: _____
☐ Suicide talk/attempts	☐ Oppositionality	_____
☐ Domestic violence	☐ History of suspensions	_____

Please summarize the current event or circumstances that lead to this referral:

_____

_____

_____

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Please send the following documents with this referral. The documents should provide chronological diagnostic and treatment information relating to the concerns listed in the previous section. If the records do not contain relevant information, please attach a narrative to provide additional information.

Documentation	**Attached**	**N/A**
• Current IEP	☐	☐
• Eligibility statement	☐	☐
• Most recent academic/intellectual functioning assessment	☐	☐
• Most recent psychological assessment	☐	☐
• Most recent psychiatric assessment (if available)	☐	☐
• Intake & discharge and/or most recent treatment review (for student in the hospital or treatment setting during the past 2 years)	☐	☐
• Functional Behavioral Assessment/Behavior Support Plan	☐	☐
• Current mental health assessment (within the past 12 months)	☐	☐
• Current transcript (high school students only)	☐	☐

Please indicate discharge criteria for this student:

_____

_____

_____

_____

_____

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