



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)

**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:

- | | | |
|--|--|--|
| <input type="checkbox"/> History of non-attendance | <input type="checkbox"/> Weapons | <input type="checkbox"/> Multiple school placements |
| <input type="checkbox"/> Academic deficits | <input type="checkbox"/> Self endangering behaviors | <input type="checkbox"/> School phobia |
| <input type="checkbox"/> Physical aggression | <input type="checkbox"/> Medication concerns | <input type="checkbox"/> Recent hospitalization |
| <input type="checkbox"/> Verbal aggression | <input type="checkbox"/> Home/family struggles | <input type="checkbox"/> Recent discharge/ plan to discharge from residential/ other treatment setting |
| <input type="checkbox"/> Substance misuse
(<input type="checkbox"/> student <input type="checkbox"/> family) | <input type="checkbox"/> Gang affiliation/
high risk of gang affiliation | <input type="checkbox"/> Property Damage |
| <input type="checkbox"/> Difficulty with peers | <input type="checkbox"/> Sexual acting out
(<input type="checkbox"/> physical <input type="checkbox"/> verbal) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Suicide talk/attempts | <input type="checkbox"/> Oppositionality | _____ |
| <input type="checkbox"/> Domestic violence | <input type="checkbox"/> History of suspensions | _____ |
| <input type="checkbox"/> Elopement (from school or home) | <input type="checkbox"/> Impulsivity/attention deficits | _____ |

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

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	<input type="checkbox"/>	<input type="checkbox"/>
• Eligibility statement	<input type="checkbox"/>	<input type="checkbox"/>
• Functional Behavioral Assessment/Behavior Support Plan	<input type="checkbox"/>	<input type="checkbox"/>
• Most recent academic/intellectual functioning assessment	<input type="checkbox"/>	<input type="checkbox"/>
• Most recent psychological assessment	<input type="checkbox"/>	<input type="checkbox"/>
• Most recent psychiatric assessment (if available)	<input type="checkbox"/>	<input type="checkbox"/>
• Intake & discharge and/or most recent treatment review (for student in the hospital or treatment setting during the past 2 years)	<input type="checkbox"/>	<input type="checkbox"/>
• Current mental health assessment (within the past 12 months)	<input type="checkbox"/>	<input type="checkbox"/>
• Current transcript (high school students only)	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate discharge criteria for this student:
