

Therapeutic Educational Center
Referral Form
Revised 6/25/09

Instructions for completing form:

This referral form is comprised of three sections that need to be completed by three separate entities: the referring school, the parents/guardians and AMCH. The referral form must be **COMPLETELY** filled out to be considered by the TEP Screening Committee. Referral forms with items left blank will be returned for completion. Referring school/agency, **Please be sure to complete the return address portion at the top of each section.** It is the responsibility of the referring school/agency to distribute the parent section of this form to parents/guardian, collect the completed sections, and submit the entire, completed referral form to the TEC Supervisor.

To be completely fill out then returned to: (address of school/agency that sent form)

Agency/School Name _____
Street Address _____ City/State/Zip _____
Phone _____ Fax _____
Contact Person _____

Student Name _____ Social Security Number _____

Gender _____ Date of Birth _____ Age _____ Grade _____ IEP _____ YES _____ NO

If yes, percent/time in SpED _____ Area of Exceptionality _____

Parent/Guardian _____ Relationship to child _____

Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Referred by: School _____ Mental Health _____ SpEd _____ Other _____

Person Referring _____ Title _____

Date of Referral _____

Referring School Section
To be completely filled out by the referring school

Principal _____

SpEd Instructor _____ School Psychologist _____

Person responsible for referring student materials: _____

Academic issues (attach supporting evidence including IEP):

Intervention strategies (attach supporting evidence):

School behavioral issues:

Intervention strategies to manage school behavioral issues:

Social skills issues:

Submit a copy of the student's behavioral plan with evidence of success and failure.

Previous or current risk of injury to self or others:

Other information to be considered (general education interventions, student improvement reports, etc.):

The Therapeutic Educational Center (TEC) begins the transition process back to the referring school the day the student is admitted to the program. The TEC goal for the student is to assist him/her in getting his/her behavior to a manageable level. The referring school will specify the specific concerns leading to the referral as well as the behavior expectations for the student to return. Utilizing this information, the TEC staff will prioritize the behaviors to be targeted for treatment and set transition goals. It is understood that TEC staff will outline the transition timeline when the process begins. It is the referring school's responsibility to provide transportation after the first week of the transition timeline.

Please list in order of importance the specific concerns and behaviors that lead to the referral to TEC.

1. _____
2. _____
3. _____
4. _____

Please list the behavioral expectations for the student to achieve while at TEC.

1. _____
2. _____
3. _____
4. _____

Parent/Guardian Section

To be completely filled out by the student's parent/guardian then returned to:

(Address of school/agency that sent form)

School/Agency Name _____
Street Address _____
City/State/Zip _____
Phone _____
Contact Person _____

Student Name _____

Parent/Guardian _____ Parent__ Foster Parents__ Other _____

Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Foster Care Contact Person _____ Title _____

Address _____ City/State/Zip _____

Phone _____ Fax _____ Cell Phone _____

Behavioral issues at home:

Behavioral issues at school:

Medical history:

Family mental health history:

Developmental history, including pregnancy:

Previous or current risk of injury to self or others:

Previous or current home environment issues (parental: substance abuse; employment; etc.):

Previous or current court legal issues:

Previous or current substance abuse:

Other pertinent information:

Mental Health Agency Section
To be completely filled out by the student's mental health agency

Student Name _____ Agency _____

Phone _____ Therapist _____

Case Manager _____

DSM IV Diagnosis:

Axis I _____

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

Previous or current mental health treatment (attach copy of treatment plan if available):

Previous or current hospitalization(s) for mental health issues (attach copy of discharge if available):

Medications for mental health issues:

History of abuse (physical, sexual, emotional):

History of neglect or inadequate supervision:

Previous or current risk for injury to self or others:

Social skills issues:

Family mental health history:

Previous or current home environment issues (parental: substance abuse; employment; etc.):

Previous or current court or legal issues:

Previous or current substance abuse issues:

Other pertinent information:
