



**NW Regional ESD**

**Referral for Behavior Specialist Services**

**Request (Please Check One)**

<input type="checkbox"/>	Consultation to General Ed Team: Facilitation of FBA & Behavior Support Plan <b><u>REQUIRED Attachment: Intro Letter with Parent Signature</u></b>
<input type="checkbox"/>	Consultation to IEP Team: IEP development <b><u>REQUIRED Attachment: Notice of IEP Team Meeting</u></b>
<input type="checkbox"/>	Consultation to IEP Team: Facilitation of FBA & Behavior Support Plan <b><u>REQUIRED Attachment: Notice of IEP Team Meeting</u></b>

**Student Information**

Name: _____	Date of Birth: _____
Parent/Guardian: _____	SSID#: _____
Home Phone: _____	District: _____
Alternate Phone: _____	Home School: _____
Attending School: _____	Grade Level: _____

**School Psychologist Involved:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Interpreter Needed (check one):** \_\_\_ Yes\* \_\_\_ No **Language:** \_\_\_\_\_

\* If "Yes", contact person: \_\_\_\_\_ Phone number: \_\_\_\_\_

**Case Coordinator Information**

Contact Person: _____	Position/Title: _____
Email Address: _____	Phone/Extension: _____
Mailing Address Street: _____	Current IDEA Elig. (if applicable): _____
City/State/Zip: _____	Current IEP Date: _____

**Principal Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Sped Director Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PLEASE SUBMIT FORM/ATTACHMENTS ATTN: EMILY CREEL/CLATSOP SC**

**If you have questions regarding referrals or documentation requirements, contact the Mental Health Services Coordinator at 503/614-1654 or speak with your supervisor.**

**Date Rec'd:** \_\_\_\_\_ **Date sent to Clatsop SC:** \_\_\_\_\_ **Date Rec'd at Clatsop SC:** \_\_\_\_\_