

REFERRAL FOR BEHAVIOR CONSULTANT SERVICES

STUDENT NAME: _____ DATE OF BIRTH: _____
 SCHOOL: _____ GRADE: _____ SE ELIGIBILITY: _____
 SE TEACHER: _____ GE TEACHER: _____
 REFERRING TBA STAFF: _____ DISTRICT CONTACT AND PHONE: _____

PARENT NAME: _____	PARENT NAME: _____
ADDRESS: _____	ADDRESS: _____
CITY/STATE/ZIP: _____	CITY/STATE/ZIP: _____
PHONE #: _____ CELL #: _____	PHONE #: _____ CELL #: _____
LEGAL GUARDIAN: ___ YES ___ NO	LEGAL GUARDIAN: ___ YES ___ NO
REFERRAL DISCUSSED WITH PARENT? ___ YES ___ NO	REFERRAL DISCUSSED WITH PARENT? ___ YES ___ NO

The following is required prior to request for Behavior Consultant services. Please document with dates and appropriate supporting evidence prior to submission to Service Area Supervisor and TBA Behavior Services Department.

Medical/Medication Information: _____
 Outside Agency Involvement: _____
 Reason for Referral (Behaviors of concern): _____

DOCUMENTS TO ATTACH:

- Functional Behavioral Assessment (including dates and pertinent medical information)
- Behavior Intervention Plan with Positive Behavior Supports (including data demonstrating effects of plan) Include previous BIPS
- Most recent IEP and MET reports
- Parent Input
- Incident reports– behavior logs
- Data demonstrating effect (or lack) of intervention(s) on behavior(s)
- Current emergency information
- Special Education History

SERVICE AREA SUPERVISOR OF SPECIAL EDUCATION:

Date of contact to discuss this referral: _____

After reviewing all information related to this case, I:

- Find substantial documentation of empirically supported interventions or have determined that the nature and severity of the behaviors of concern warrant this level of intervention.
- Recommend further interventions prior to Behavior Specialist involvement.

Service Area Supervisor

Date

SERVICE AREA SUPERVISOR- PLEASE FORWARD TO TRACY HUHN OR ALLEEN POPP AT TBA ADMINISTRATION - EAST WITH **ALL** NECESSARY INFORMATION AND ATTACHMENTS.