Date of Referral: _____

Wesley Schools Referral Form

Wesley Schools

Except for acute referrals, all referrals should be submitted with educational records such as ER, RR & IEP (if applicable), immunizations, transcripts, grades, and discipline records.

Program of Interest:

☐ **School Placement (☐ Approved Private School / ☐ Private Education) An educational entity must submit this referral.** A school placement for students in grades 1-12. Level of care for mental health services will be assessed at intake.

☐ **Acute Referrals only accepted Mid-August through Mid-May. Anyone may submit.** A mental health placement designed as a short-term stabilization program typically lasting 10-15 days utilized to prevent a hospitalization or as a step down from one, for clients who are exhibiting new or increasing behaviors occurring within the past two weeks. **REFERRAL EXPIRES AFTER 45 DAYS**

☐ **30 Day K-8 Assessment An educational entity must submit this referral.** A short-term assessment program designed for students who are at risk for out-of-school district placement due to behavioral or mental health needs. Students receive a mental health assessment which includes observation from a behavioral health professional, psychiatric evaluation, risk assessment and psychological screening. REQUIRES MEDICAL ASSISTANCE.

☐ **30 Day High School Assessment An educational entity must submit this referral.** A short-term assessment program designed for students who are at risk for out-of-school district placement due to behavioral or mental health needs. Students in grade 9-12 who are in regular education or special education and are experiencing regression which necessitates a time-limited placement for evaluation and brief intensive treatment. Funding for portions of this program is provided by your health insurance and your school district.

☐ **45 Day Placement An educational entity must submit this referral.** Designed for students who are in need of an educational placement due to an incident that occurred within the school setting.

☐ **Kindergarten/School Readiness Program at Monroeville An educational entity must submit this referral.** Designed to increase emotional regulation skills and academic school readiness to enable children in Kindergarten to learn successfully in their regular school setting. This setting is private education only.

☐ **Kindergarten/School Readiness Program at K-8 An educational entity must submit this referral.** Designed to increase emotional regulation skills and academic school readiness to enable children in grades K-2 to learn successfully in their regular school setting. This setting is private education only.

☐ **Bridge Program An educational entity must submit this referral.** Provides individualized, positive, strengths-based strategies to transform the lives of youth ages 17-21 who have cognitive and emotional disabilities. Uses a multiple curriculum approach which includes ongoing assessment, daily living skills, employment skills, self-determination and building healthy relationships skills.

☐ **ESY An educational entity must submit this referral.** Designed to provide an extended school year program for eligible students in grades K-12.

Child/Adolescent Information

Name: _____ **Date of Birth:** _____ **Age:** _____

Social Security Number: _____ **Race (optional):** _____

Sex Assigned at Birth: ☐ M ☐ F **Gender Identity:** ☐ M ☐ F **Other:** _____

Pronouns: _____

Current Address: _____

Legal Involvement: ☐ Y ☐ N **CYF Involvement:** ☐ Y ☐ N **Family in agreement with Referral?** ☐ Y ☐ N

School Information

Current School: _____ **School Contact:** _____

School Contact Email: _____ **School Contact Number:** _____

School District: _____ **PA Secure ID#:** _____

Grade: _____ **Special Ed:** ☐ Y ☐ N **If yes, primary disability category:** _____

Date of IEP: _____ **Date of ER/RR:** _____ ****must include copies with the referral**

Continued on back.

Parent/Caregiver Information

Primary Caregiver Name: _____

Primary Phone Number: _____ Primary Email: _____

Secondary Caregiver Name: _____

Secondary Phone Number: _____ Secondary Email: _____

Emergency Contact(s): _____ Phone: _____

Who Has Legal Custody of Child? _____ Are there Custody Documents: ☐ Y ☐ N

*If yes, a copy is required

Educational Decision Maker (if not parent): _____ Phone: _____

EDM Email: _____

Medical Decision Maker (if not parent) _____ Phone: _____

MDM Email: _____

Insurance Information (if known)

Primary Insurance: _____ Secondary Insurance: _____

Policy or MA#: _____ Policy or MA#: _____

Referral Source

Name: _____ Agency: _____

Phone: _____ Fax: _____ Email: _____

Symptom Description (Be as specific as you can as this information helps us to determine the client's level of care needs)

-Aggression: ☐ Not Present ☐ Verbal ☐ Physical/Fighting ☐ Property Destruction

Explain/Frequency: _____

-Elopement: ☐ Not Present ☐ Out of Classroom ☐ Out of Building

Explain/Frequency: _____

-Throwing Objects: ☐ Not Present ☐ At People ☐ Around the Room ☐ Big Objects (Chairs) ☐ Small Objects (Books)

Explain/Frequency: _____

-Substance use/abuse: ☐ Not Present ☐ Present ☐ Unknown

Explain/Frequency/Type: _____

-Suicidality: ☐ Not Present ☐ Ideation ☐ Plan ☐ Gesture ☐ Attempt ☐ Unknown

Explain/Frequency: _____

-Self-Injury: ☐ Not Present ☐ Yes ☐ History ☐ Unknown

Explain/Frequency: _____

-Homicidally: ☐ Not Present ☐ Ideation ☐ Plan ☐ Gesture ☐ Attempt ☐ Unknown

Explain/Frequency: _____

-Psychosis/Hallucinations: ☐ Not Present ☐ Audio ☐ Visual ☐ Delusions ☐ Paranoid Ideation ☐ Unknown

Explain/Other: _____

-Abuse history: ☐ Not present ☐ Physical ☐ Emotional ☐ Sexual ☐ Unknown / Reported to CYF? ☐ Yes ☐ No

Explain/Other: _____

-ASD/Cognitive: ☐ Not Present ☐ ASD/Autism ☐ Nonverbal ☐ ID

Explain/Other: _____

Continued on next page.

-Conduct: ☐Not Present ☐Stealing ☐Fire Setting ☐Animal Cruelty ☐School Truancy ☐Runaway

Explain/Other: _____

-IQ Score: _____

Reason for Referral:

CURRENT DIAGNOSTIC IMPRESSION: (List Primary Diagnosis First / If known)

Diagnosis:_____

MEDICAL: ☐None ☐Asthma ☐Headaches/Migraines ☐Allergies w/ EpiPen ☐Seizures ☐Diabetes ☐Cardiac Diagnosis

Explain/Other:_____

Medication(s):_____

CURRENT AND PAST MENTAL HEALTH PROVIDERS (if known):

Please email the completed referral to IntakeDepartment@wfspa.org (preferred) or fax 412-347-3188