

Wesley Schools Referral Form



Wesley Schools

Date of Referral: _____

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.

Wesley Primary School (K-3) & 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