



## Ventura County SELPA

# REFERRAL FOR SOCIAL/EMOTIONAL SPECIALIST SERVICES

(prior to referral to ERSES)

### CONTACT PERSON

Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
District: \_\_\_\_\_ School: \_\_\_\_\_  
Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

### STUDENT

Name: \_\_\_\_\_  
Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_  
Grade: \_\_\_\_\_ Age: \_\_\_\_\_  
District: \_\_\_\_\_ School: \_\_\_\_\_  
Disability: \_\_\_\_\_  
Parents/Guardian Names: \_\_\_\_\_  
Current special education programs and services: \_\_\_\_\_  
\_\_\_\_\_

Please describe the social/emotional and/or behavior issues that cause you to make this referral, and how long this has been occurring. Please briefly address the support and interventions that have been implemented so far. Include social/emotional or behavioral goals included in the IEP.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Anticipated Needs:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Counseling           | <input type="checkbox"/> Functional Behavioral Assessment | <input type="checkbox"/> Behavior Intervention Plan |
| <input type="checkbox"/> Social Work Services |   | <input type="checkbox"/> Other                      |
| <input type="checkbox"/> Parent Counseling    |   |   |

Release attached:  Yes  No

IEP attached:  Yes  No

Psychological Report:  Yes  No

(SELPA use only)

Date received: \_\_\_\_\_  
Staff assigned to follow-up: \_\_\_\_\_  
Follow-up contact made: \_\_\_\_\_