UNIVERSITY *of* MISSOURI

ASSESSMENT & CONSULTATION CLINIC

REFERRAL FORM: SCHOOLS/AGENCIES

STUDENT/CHILD INFORMATION

Student Name
(Last):_________________________________ **(First)**_________________________________ **DOB:** _____________ **Age:**______ **Sex:**______

Parent/: _________________________ **Street address:** ____________________________ **City:**_____________ **State:** _____ **Zip:** _________
Guardian

Grade: ___________ **Teacher (ELEMENTARY only):** ______________________________ **School:** ___________________________________

REFERRING AGENCY/SCHOOL DISTRICT INFORMATION

School/Agency
Street address: _______________________________________ **City:** ____________________________ **State:** ________ **Zip:** ____________

County (Agencies)/
School District (Schools): ____

***REFERRAL CONTACT PERSON*:** ______________________________________ **Job Title:** ____

Phone: ________________________ **Fax:** _______________________ **Email:** ____

Address To
Send Information: _______________________________________ **City:** ___________________________ **State:** _______ **Zip:** ____________
(Leave blank if same as above):

District/Agency Authorized Signature: ____ **Date:** _________________

(__NOTE__: The referring agency/school district is responsible for obtaining permission to assess the child/student, explaining parental rights, and conducting reconciliation/resolution meetings, due process hearings, or appeals)

REFERRAL REASON(S) (Check all that apply)

Behavior/Conduct:
- ☐ Oppositional or noncompliant
- ☐ Aggression
- ☐ Difficulty getting along w/adults
- ☐ Hyperactivity or impulsivity
- ☐ Poor attendance/truant
- ☐ Substance abuse concerns
- ☐ Harm to others or animals
- ☐ Harm to self
- ☐ Harm to property

Abuse:/Neglect
- ☐ Verbal/emotional
- ☐ Physical
- ☐ Sexual
- ☐ Physical neglect
- ☐ Emotional neglect
- ☐ Educational neglect

☐ **Medical or medication issues (Describe):**
____
____

Social/Emotional
- ☐ Sadness or depression
- ☐ Worry or anxiety
- ☐ Frustration or stress
- ☐ Anger
- ☐ Difficulty getting along with peers
- ☐ Grief issues
- ☐ Family problems
- ☐ Somatic symptoms (unexplained aches/sickness/pain)
- ☐ Social skills

Cognition/Thinking:
- ☐ Verbal
- ☐ Nonverbal
- ☐ Processing speed
- ☐ Working memory
- ☐ General memory
- ☐ Adaptive skills
- ☐ Hallucinations
- ☐ Delusions

Academic/Learning:
- ☐ Reading
- ☐ Writing
- ☐ Math
- ☐ Attention or concentration

Communication/Speech/Language:
- ☐ Expressive language
- ☐ Receptive language
- ☐ Repetitive vocalizations
- ☐ Articulation
- ☐ Emotion recognition/response

Physical/Motor:
- ☐ Repetitive motor movements
- ☐ Tics
- ☐ Gross motor delays
- ☐ Fine motor delays
- ☐ Sensory issues

☐ **Other:**
____
____

(__NOTE__: If you are requesting a single assessment to be administered, please specify type (e.g., IQ, Achievement) in the "other" section above and DO NOT complete the remaining portion of this form unless necessary/appropriate)

Provide a brief summary of why the evaluation is being requested**:**
____

____

Has this child been evaluated before? (if yes, please describe below): ☐ **YES** ☐ **NO** ☐ **UNKNOWN**
(If additional space is required, indicate so and attach a page at the end of this form)

Date	Type of Assessment/Evaluation	School/Agency Name & Location	Results/Diagnosis/Decision

(<u>NOTE</u>: Please attach any supporting documentation)

In the box below, Indicate (YES/NO) regarding the child's previous/current educational placement and describe any services/accommodations the child has been provided.

	Previous (if yes, specify dates)	Current	Services/ Accommodations
General/Regular Education			
Special Education IEP 504 Plan			
Vocational/Technical			
Residential Home/School Placement			
Homebound			
Not Enrolled			
Other ____________________			

(<u>NOTE</u>: Please attach any supporting documentation)

Briefly describe any other relevant information: ____

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Thank you for your referral! Once this form is received, you will be contacted to discuss the type of evaluation and to arrange an appointment date/time/location. In order to ensure our services are tailored to the specific needs of the school and student, on-site appointments will be scheduled *<u>after</u>* this form is completed and received. Please refer to the "Evaluation Checklist/Flowchart" for guidelines. You may either *fax* the Referral Form and supporting documentation to the MU-ACC at (573) 884-3399 or *mail* to:

MU Assessment & Consultation Clinic
Attn: Christina Pate
205 Lewis Hall
Columbia, MO 65211

<u>Please contact Christina Pate at patecm@missouri.edu or (573) 884-0377 for notification of submission.</u>**

<u>For office use only</u>

Date received: ____________________ Comments:

Form complete? ____________________

Consent received? ____________________

Date of follow-up: ____________________

Type of eval: ____________________

Staff Initials: ____________

Date of eval: ____________________