# DirectCare Community Base Services, LLC

"P.R.I.D.E, Promoting Responsibility In Decision Making for Everyone"

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## DAY TREATMENT STUDENT REFERRAL

Name _____ School _____

Grade _____ Date of Birth _____

Current Interventions Utilized _____

_____

_____

_____

Special Education Placement? (Yes or No) Specify Placement _____

Medicaid # _____ Social Security # _____

Parent/Guardian _____ Phone #'s _____

Has parent/guardian been contacted by school staff RE: referral of student to DCDTP? _____yes _____no

REASON FOR REFERRAL (Please circle the behaviors below that are interfering with the child's ability to be successful at school.)

Inattentive Hyperactive Poor Social Skills Disruptive Anger Outbursts Truancy

Aggressive/Violent Argues/Defies Adult&School Authority Low Self-Esteem

Recent Loss Stress at Home Health Problems Mental Health Illness

Others_____

Significant family issues affecting the child (please explain) _____

_____

Personal Strengths/Positive Characteristics of Child _____

_____

Other relevant information _____

PRINT NAME OF REFERRING PERSON: _____

SIGNATURE _____ DATE: _____