EDUCATIONAL SERVICE UNIT NO. 11

412 W. 14TH AVE. • P.O. BOX 858
HOLDREGE, NE 68949-0858

TELEPHONE (308) 995-6585 • FAX (308) 995-6587
WWW.ESU11.ORG

Request for Behavioral Screening and/or Consultation

Student _____ School _____

Date of Birth _____ Grade _____

Parent(s) _____ Teacher _____

Home phone _____ Work phone _____ Other phone _____

Referred by:

☐ Student Assistance Team (SAT), ☐ 504 Team, ☐ IEP Team
Name of SAT, 504, or IEP Contact Person _____
☐ Parent
☐ Doctor (or other professional)
Name of referring professional _____

Reason for referral:

Outcome(s) expected as a result of the referral:

Check one of the following to Consent, Request Conference, or Deny Consent:

☐ I am aware of the above-listed reasons for my child's referral and **DO GIVE CONSENT** for screening and consultation completed by the ESU 11 School Psychologist.

☐ I am aware of the above-listed reasons for my child's referral and **DO NOT GIVE CONSENT** at this time for screening and consultation completed by the ESU 11 School Psychologist.

If you have any questions, please call _____.

Check the following to provide release of information:

☐ If one expected outcome of this referral is consultation with an outside service provider (for example, a doctor or therapist), I also **GIVE CONSENT FOR EXCHANGE OF INFORMATION** between the ESU 11 School Psychologist and the professional listed below:

Name _____
Address _____
_____
Phone _____ Fax _____

Parent Signature _____ Date _____