Date of Referral: _____

Wesley Schools Referral Form

Wesley Schools

Thank you for understanding that only COMPLETE (every section filled in) referrals will be accepted and processed.

With the exception of 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.

____ **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: _____ **City and State of Birth:** _____

***if not PA, mo/yr moved to PA:** _____

Race (optional): _____ **Sex:** ____ **M** ____ **F Past Admission to WFS Program:** ____ **Y** ____ **N**

Current Address: _____

Legal Involvement: ____ **Y** ____ **N** **CYF Involvement:** ____ **Y** ____ **N**

School Information

Current School: _____ **School Contact:** _____

School District: _____ **PA Secure ID#:** _____

Continued on back.

Grade: _____ Special Ed: ____ Y ____ N If yes, primary disability category: _____

Date of IEP: _____ Date of ER/RR: _____ *must include copies for any educational referrals

Parent/Caregiver Information

Primary Caregiver Name(s): _____

Home Phone: _____ Cell Phone: _____ Email: _____

Emergency Contact(s): _____ Phone: _____

Who Has Legal Custody of Child? _____ Are they 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: _____

Date of IEP: _____

Insurance Information (referral will be returned if this section is not completed)

Primary Insurance: _____ Secondary Insurance: _____

Policy or MA#: _____ Policy or MA#: _____

Referral Source

Family in agreement with Referral? ____ Y ____ N

Name: _____ Agency: _____

Phone: _____ Fax: _____ Email: _____

Reason for Referral and School District Expectations for Return (Be as specific as you can as this information helps us to determine the client's level of care needs)

Expected Length of Stay: _____

Current Medical Information

Current Medications: _____

Note any Allergies or Medical Conditions: _____

_____

Please email the completed referral to IntakeDepartment@wfspa.org (preferred) or fax 412-347-3188