

Lycoming Office: 200 East Street Williamsport, PA 17701 (570) 326-7895 Clinton Office 8 North Grove Street Lock Haven, PA 17745 (570) 748-2262

FOR CASSP USE ONLY	

Individuals completing this referral for a CASSP meeting must also submit a completed CASSP release of information form (see attached). The information release must include any public/private agencies and schools that are involved with the child and/or family. Information contained in this form is confidential and should be completed with the consent and knowledge of the child and family.

*Referrals that are not completed in their entirety may be delayed. *

	IN	TAKE PACKET	
	CHILD DEM	IOGRAPHIC INFORMAITON	
Name:		MAID:	
DOB:	Age:	Sex: Race:	_
Address:		Phone Number:	_
City:		County of Residence:	_
Zip:		Primary Language:	_
Does a translator need to be	provided by school/orga	nization:	
		RANCE INFORMATION	
Insurance: HealthCHoices/CCE Notes on Insurance:		e Medical Insurance Fee-For-Service	- -
Reason for Referral (choose min	imum of one):		
School Attendance	Service Compliance	Is MH Case Management involved:	
Service Coordination	Medical Issues	Agency:	
Educational Placement	Team Planning	Contact:	
Behavior Support	Services Ineffective	IQ: Above 70 Below 70 Unknown	
		IQ: Above 70 Below 70 Unknown	

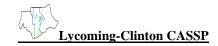
1.			
	Name:	Role:	DOB:
	Address:		
	Phone:	Email:	
2.	Name:	Role:	DOB:
	Address:		
	Phone:	Email:	
3.	Name:	Role:	DOB:
	Address:		
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SCHOOL INFORMATION							
School District:	Grade:						
School Building/Alternative Placement:	Dates of Placement:						
Primary School Contact:	Title:						
Other School Representatives:							
Does the child receive any of the following (check all that apply):							
Emotional Support Learning Support Autistic Support	ort Life Skills 1:1 Aide						
Speech Occupational Therapy Physical Thera	ppy 504 Plan IEP (Individualized Education Plan)						
Has there been a Functional Behavioral Assessment (FBA) completed:	Date:						
Please attach any school feedback: 504 Plan, IEP, ODRs (Office Disciplin and FBA (Functional E							
Please provide any additional school information and/or concerns:	renavioral Analysis)						
Protective	: Factors						
Please List the Child or Adolescent's Strengths:							
Please List the Family's Strengths:							
Please List the Member/Family's Community Supports:							



		Further Note
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Contact:		
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is:	Date of recent Assessment/Evaluation:					
Service Type		Provider			Assigned Worker	
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<u>ion:</u>						
			Most Recent Medicati	on Visit:		
			Most Recent Medicati Prescriber	ion Visit: Notes:		
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edications: Medication I	Name Dosa _l	ge	Prescriber	Notes:		
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PHYSCIAL HEALTH INFORMATION
Primary Care Physician (PCP): Provider:
Date of most recent Physical/Examination:
Please rate the child's health: Good Fair Poor
Did the child/adolescent meet developmental milestones:
Does the child/adolescent have any Serious Illness/Diagnosis/Predisposing Factors that impact behavior:
Other Specialist:
NOTES:
RISK ASSESSMENT
Is the child/adolescent a victim of:
Past Current
Physical Abuse Emotional Abuse Neglect Sexual Abuse Domestic Violence
NOTES:
Is the child/adolescent a perpetrator of:
Past Current
Physical Abuse Emotional Abuse Neglect Sexual Abuse Domestic Violence
NOTES
In the shill assuments CI/III.
Is the child currently SI/HI: Notes:
Does the child have a history SI/HI: Notes:
SI = Suicidal Ideation HI = Homicidal Ideation



Please List Any Additional Information or Concerns					
What Is the Desired Outcome of CASSP Involvement:					
what is the Desired Outcome of CASSF involvement.					
Scheduling: Please indicate any times of days, days of week, or barriers to scheduling.					
CASSP Support Meetings may occur via agency, school, virtual, or agency.					
Submit completed packets via encrypted email, mail, fax, or in person					
Submit completed puckets via entrypted email, mail, jux, or in person					
Referral Source: Date: Date:					
Phone Number: Email:					
Has a Release of Information (ROI) been completed or provided: Date:					



CASSP SUPPORT CONTACT LIST

NAME	AGENCY	ROLE/TITLE	PHONE	EMAIL