

EDUCATIONAL SERVICE DISTRICT **112**
Wellness and Treatment Services

Referral Form

Date: _____

Name: _____
 First M.I. Last

Address: _____
 Street Apt # City State Zip

Date of Birth: _____ Gender: Male Female Other

School: _____ Grade: _____

For youth 13 and over, does ESD 112 Wellness and Treatment Services have permission to contact the parent? Yes No

Parent/Guardian Name: _____

Phone: _____ Cell Home Okay to leave message?

Is the parent employed outside the home? Yes No

If yes, can we call the parent at work? Yes No Work Phone: _____

Referent Name: _____ Phone: _____

Any accommodations required? (Interpreters) Yes No

Reason for Referral:

