

OAK HILL SCHOOL

"A Small School with Big Expectations"

39 Charlton Road, Scotia, NY 12302

Telephone 518-399-5048 ext 110

FAX 518-399-6140

E-Mail: oakhill@oakhill.org

Website www.oakhill.org

David Mitchell
Executive Director

District Referral Form

Student:

Name: _____

Grade: _____ DOB: _____

Date of Referral : _____

District: _____

District Contact

Name: _____ Title: _____

Phone: _____ Email: _____

Parent/Guardian Information:

Parent/Guardian Name: _____	Parent/Guardian Name: _____
Relationship to Student: _____	Relationship to Student: _____
Custodial Parent? Y/N	Custodial Parent? Y/N
Reside with child? _____	Reside with child? _____
Day phone _____	Day phone _____
Evening phone _____	Evening phone _____
Email: _____	Email: _____
Mailing address if different from student: _____ _____	Mailing address if different from student: _____ _____
Receive correspondence? Y/N	Receive correspondence? Y/N

Reason For Referral
(behavior, attendance, suspensions, health, etc.)

Current Placement (Include start date)

Previous Placements (Include start/end dates)

Outside Agency/Provider Involvement

Agency/Provider	Service	Contact Name

<p>Additional Required Documents</p> <ul style="list-style-type: none"> <input type="checkbox"/> Current IEP <input type="checkbox"/> Psychoed Evaluation (within 3 years) <input type="checkbox"/> Social History <input type="checkbox"/> FBA/BIP <input type="checkbox"/> Most Recent Report Card <input type="checkbox"/> Achievement testing (within 1 year) <input type="checkbox"/> Health Record 	<p>If Applicable</p> <ul style="list-style-type: none"> <input type="checkbox"/> Speech/OT/PT Evaluations <input type="checkbox"/> Psychiatric <input type="checkbox"/> Neuropsychological <input type="checkbox"/> Any other outside evaluations
--	--

Has the child been referred to other agencies ? Y/N

If yes, indicate where and status of referral:
