Linkages to LEARNING

REFERRAL FORM

DATE: _____ SCHOOL: _____

FROM: _____ TITLE: _____

REFERRAL PROTOCOL:

By filling out this referral form, the referral source is verifying that the parent/guardian of the student referred has verbally consented to this referral and the disclosure of the information below to Linkages to Learning (LTL). Services provided by LTL are funded by the Montgomery County Department of Health & Human Services (MCDHHS). The identifying information below will allow LTL staff to learn about prior or current services provided to the student and/or parent/ guardian by MCDHHS in order to best coordinate and plan for providing support to this family. *EXCEPT WHERE OTHERWISE NOTED, ALL FIELDS ON THIS FORM ARE REQUIRED TO BE FILLED OUT FOR LTL TO PROCESS THIS REFERRAL.*

_____ *(If referred from EMT/CAP, attach meeting notes)*

Signature of Referral Source

STUDENT INFORMATION	**PARENT/GUARDIAN INFORMATION**
Name _____	Name _____
SID# _____	Relationship _____
Address _____	DOB _____
_____	Telephone _____
DOB _____	Alternate # _____
Type of Health Insurance _____	Best time to call _____
Teacher/Grade _____	
Counselor _____	

Child/Family is being referred for *(check all that apply)*:

____ LTL Parent Education/Supports ____ LTL Youth Development Activities

____ LTL Child/Family Therapy ____ LTL Family Case Management* *(complete box below)*

The information below is required for referrals to LTL Family Case Management services:

Attendance *(please check one)*:
___ Child attends school except during illness/emergency
___ Insufficient school attendance / chronic tardiness
___ Child does not participate in academic process

Academic Performance: *(please check one)*
___ Child exceeds academic standards
___ Child meets academic standards
___ Performing below academic standards

Parents' Involvement: *(please check one)*
___ Parents involved in *meeting* child's educational/developmental needs
___ Parents *involved* in child's educational/developmental needs
___ Parents aware but unresponsive to child's developmental needs
___ Parents unaware of child's developmental needs

REASON FOR REFERRAL & RELEVANT HISTORY:

_____

_____

_____

_____

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_____

_____

ANTICIPATED SERVICE NEEDS:

____	Clothing	____	Job/employment referrals		
____	Health	____	Emergency Financial Assistance	____	Food
____	Crisis Intervention	____	Financial Planning	____	Other ↴
____	Social Skills Groups	____	Housing Assistance/referrals	(Please explain below):	
____	Parenting classes	____	Utility Assistance	_____	
____	Child care	____	Immigration/Legal referrals	_____	
____	Academic Needs	____	Eligibility screening for financial assistance		

Does parent/guardian speak English? Yes No If not, what language? _____

Is an interpreter needed? Yes No

---------- *For LTL Staff Use Only* ----------

Referral entered into eICM by: _____ on: _____
LTL Worker *Date*

Referral Feedback Form Submitted to referral source on: _____
Date

cc: ___ School Counselor ___ PCC ___ PPW ___ LTL CFT ___ LTL CSC

___ Principal ___ AP ___ Teacher ___ LTL FCM ___ LTL CSA

___ Other: _____