

SCUSD - COST/RIS Referral Form

(Coordination of Services Team: For students needing support after Tier 1 efforts have been exhausted.)

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NOTE: If you suspect Child Abuse or Neglect **YOU MUST** notify CPS at 916-875-5437. For Safety Concerns, contact Police at 916-808-5471

STUDENT INFORMATION:

Student Name:	Date of Birth:	Sex:	Student Start Date:
Teacher Name:	School/Class:	Referred By:	

PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name:	Relationship	Street Address	Zip Code
Phone #1	Phone #2	Is an SST meeting needed?	Yes No Child has an IEP Yes No
Primary language spoken at home? English Other:		Is the student EL? Yes No	

Services Offered/Already in Place	Community Services																				
<table border="0"> <tr> <td>RIS</td> <td>Yes</td> <td>No</td> <td>Unsure</td> </tr> <tr> <td>SST</td> <td>Yes</td> <td>No</td> <td>Unsure</td> </tr> <tr> <td>Active IEP/Special Education</td> <td>Yes</td> <td>No</td> <td>Unsure</td> </tr> <tr> <td>504 Plan</td> <td>Yes</td> <td>No</td> <td>Unsure</td> </tr> <tr> <td>Other (Explain)</td> <td>Yes</td> <td>No</td> <td>Unsure</td> </tr> </table>	RIS	Yes	No	Unsure	SST	Yes	No	Unsure	Active IEP/Special Education	Yes	No	Unsure	504 Plan	Yes	No	Unsure	Other (Explain)	Yes	No	Unsure	To the best of your knowledge, is the student and/or the family receiving services from any community service providers? Yes No Unsure If so, who?
RIS	Yes	No	Unsure																		
SST	Yes	No	Unsure																		
Active IEP/Special Education	Yes	No	Unsure																		
504 Plan	Yes	No	Unsure																		
Other (Explain)	Yes	No	Unsure																		

REASONS FOR REFERRAL: MARK ALL THAT APPLY

Communication Concern	Social-Emotional/Behavioral Concern	Health/Medical/Basic Needs	Attendance Concern
Cognitive Skills	Parent Request	Other (explain):	

Please provide a detailed description of the observed behaviors / reason for referral:

Please list the interventions already attempted with the outcome in detail below (such as Teaching Pyramid interventions, STAR, child choice, strategies from your toolbox, calming station, deep breathing, sensory tools):

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REFERRED BY: Please share the completed form to your coordinator. Thank you!

Name	Title	Date Submitted
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Parent/Guardian Consent (Child Observation requires parent/guardian consent below)

I consent to have my child observed and/or screened by any of the following SCUSD professional support staff: *SCUSD Early Learning & Care support staff, nurse, coordinator, special education staff.*

I do NOT consent to my child being observed and/or screened.

Parent/Guardian Signature	Date Submitted
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Action items (suggested interventions, next steps, reasoning):	Person(s) responsible: