LEBANON COUNTY CTC
STUDENT ASSISTANCE PROGRAM
REFERRAL FORM

STUDENT'S NAME _____

ADDRESS _____ **PHONE #**_____

_____

DATE OF BIRTH _____**AGE**_____**SEX**_____

PROGRAM _____

SCHOOL DISTRICT_____**GRADE**_____

REFERRAL SOURCE_____**DATE OF REFERRAL** _____

REASON FOR REFERRAL TO SAP TEAM

____ Drug & Alcohol	____ Codependency	____ Dual Dx
____ Child Abuse	____ Sexual Abuse	____ Truancy
____ Family Issues	____ Academic Performance	____ Suicide
____ Mental Health	____ Other	

LIST <u>OBSERVABLE</u> BEHAVIORS OR DIRECT COMMUNICATION FROM STUDENT

_____

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_____

_____

_____

_____

IF INSTRUCTOR REFERRED, HAS PARENT BEEN CONTACTED? YES___ NO___

TEAM CASE MANAGER_____

DATE PARENT PERMISSION FORM WAS RECEIVED/SIGNED_____