



**EDUCATIONAL SERVICES UNIT**  
 Burlington County Special Services School District  
 20 Pioneer Blvd., Westampton, NJ 08060-3824  
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**REQUEST FOR STUDENT ANXIETY SUPPORT SERVICES**

Student Name: \_\_\_\_\_ NJ Smart SID#: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Parent /Guardian: \_\_\_\_\_ Phone/Home: \_\_\_\_\_  
 Address: \_\_\_\_\_ Cell: \_\_\_\_\_  
 District: \_\_\_\_\_ School: \_\_\_\_\_  
 Case Manager/ Guidance Counselor: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Business Administrator: \_\_\_\_\_ Phone: \_\_\_\_\_  
 District Web address: \_\_\_\_\_  
 Classified Student: Yes No Classification (Attach copy of IEP): \_\_\_\_\_  
 Reason for Referral: \_\_\_\_\_

Describe interventions that have been attempted to address the problem: \_\_\_\_\_

Student's Current Placement (if not in school): \_\_\_\_\_

Last Date Student Attended School Regularly (if applicable): \_\_\_\_\_

Services Location: \_\_\_\_\_ Phone: \_\_\_\_\_

Additional comments/information:  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature and Date indicate approval for billing

\_\_\_\_\_  
 Child Study Team Director and/or Principal

\_\_\_\_\_  
 Date

**PLEASE ATTACH ANY OTHER RELEVANT INFORMATION**

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 Anxiety services will include the following unless otherwise specified: Intake meeting with family/ school, review of documents, assessment/rating scales, report of findings, 6 in-home counseling sessions, 3 transition counseling sessions with staff & student, transition plan, monthly follow-up for 3 months, progress notes, and updated assessment.

**Please scan completed form attention:**

**Bobbie Downs**

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