EDUCATIONAL SERVICES UNIT

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Burlington County Special Services School District
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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

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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