CLARK COUNTY SCHOOL DISTRICT
STUDENT SERVICES DIVISION
WRAPAROUND SERVICES DEPARTMENT

REFERRAL FOR SCHOOL SOCIAL WORK SERVICES

Date: _____

Student's Name _____ Student Number _____ Gender _____

Date of Birth _____ School _____ PZ _____ Grade _____ Ethnicity_____

Eligibility _____ Placement _____ School Phone Number _____

Spec. Ed. Teacher _____ Reg. Ed. Teacher _____

Parent/Guardian Name _____ Primary Language of Parent _____

Home Phone _____ Work Phone _____ Emergency Number _____

Address _____ City _____ Zip _____

Type of health insurance _____

Briefly describe the situation _____

_____

Has the School-Based Mental Health Team been involved with this student? Yes_____ No_____

Has the student worked with Communities in Schools or other on-campus agency? Yes_____ No_____

Is your Safe Schools Professional involved with this student? Yes_____ No_____

What interventions have been implemented by the school team? _____

_____

Who notified the parent/guardian of this referral? _____

Date _____ Method _____

Person completing this form (Please Print) _____ Title _____

Phone _____ Fax # _____ Email _____

Social Work Department Only:

Date Case Closed: _____ Signature: _____

Please fax this form to the Wraparound Services Department at 702-799-0153 or via email to cawilliams1@interact.ccsd.net.

For more information, contact the Wraparound Services Department at 702-799-7435.

Revised 8-16-17