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| Ombudsman Referral Intake Form | Case #: . | |
| Parent/Guardian: | | |
| Telephone: | Email: | |
| School: | Date of referral: Time of Referral: | |
| Student Name:  Grade:  DOB: | Special Education  Program  If Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | yes no  yes no |
| Have any of the following people been involved? Check all that apply:   * Classroom Teacher * School counselor * Principal or administrator * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   How long has child been enrolled in this school \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Previous school \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Additional factors to be considered\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Someone in the school who has a positive relationship with the student:  Someone in the school who has a positive relationship with the family: | |
| Summary of the concerns:  Goal for requesting support: | | |