SP0008
Rev. 6/06

BEHAVIOR SPECIALIST REFERRAL

Department of Special Education
Lincoln Public Schools

Student Name:_______________________________ Date:______________________

School: _____________________ Age: _______ Gender: _______ Grade: _______

Contact Person:_____________________ Phone: ____________________ Email:__________________

Preference for contact: ❑ Phone ❑ Email ❑ Either:

Primary Disability: _____________________ Other Disability: ________________

Services Requested:

- ❑ Observation/Summary Report/Consultation
  Preferred time/period of day: ______________________________
- ❑ Attend Meeting Date/time of meeting: ______________________________
- ❑ Data Collection
- ❑ Brainstorm Ideas/Meet with Staff
- ❑ Assistance with Mandt, Crisis Intervention, Staff Development
- ❑ Assistance with appropriate curriculum
- ❑ Other ____

➤ Is this referral of a **critical nature**? ❑ Yes ❑ No

➤ Is this referral for ongoing services, continued involvement rather than brief, consultative services? ❑ Yes ❑ No

Please provide a brief explanation of the student's behavior:

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Return to: **Susan Safarik**
LPSDO, Box 43
Fax: 436-1899
Email: sbuchan@lps.org

Office Use Only:
Assigned to: ______________________________ Date: _______________

Copies to: Mary Ells, Mary Greenfield, Mary Phillips, Tanya Hilligoss