**DET new logo**Web address: [www.yarrame.vic.edu.au](http://www.yarrame.vic.edu.au)

Attach Student Photo

Email: [yarra.me.sch@edumail.vic.gov.au](mailto:yarra.me.sch@edumail.vic.gov.au)

ABN: 32 453 166 084

**YARRA ME OUTREACH PROGRAM**

**STUDENT REFERRAL 2019**

**STUDENT’S PERSONAL DETAILS**

STUDENT'S NAME: Enter details D.O.B: Enter details. CURRENT YEAR LEVEL: Enter details

HOME ADDRESS: Enter details POST CODE: Enter details

PARENT 1: Enter details. PHONE: Enter details EMAIL: Enter details

PARENT 2: Enter details PHONE: Enter details EMAIL: Enter details

CARER/GUARDIAN: Enter details

PREVIOUS SCHOOLS: Enter details

**SCHOOL DETAILS**

REFERRING SCHOOL: Enter details

ADDRESS: Enter details POST CODE: Enter details

PHONE: Enter details FAX: Enter details. EMAIL: Enter details

STUDENT WELLBEING COORDINATOR: Enter details.

CONTACT PERSON WITHIN THE SCHOOL: Enter details

REFERRAL DATE: Click here to enter a date.

CURRENT YEAR LEVEL AND SPECIALIST TEACHERS:

NAME: SUBJECT:

1. Click here to enter name. Main classroom teacher

2. Click here to enter name Subject

3. Click here to enter name Subject

4. Click here to enter name Subject

**SECTION 1** **PROGRAM**

Yarra Me School provides educational intervention programs that are designed to re-engage students in learning. This is done in partnership with their existing school using a multidisciplinary intervention approach. The aim of each program is to provide intensive and personalised supports for students at risk of disengaging from school.

Please see our website [www.yarrame.vic.edu.au](http://www.yarrame.vic.edu.au) for a description of the programs and condition requirements.

**TO BE COMPLETED BY THE REFERRING SCHOOL**

1. Reasons for referral.

Click here to enter text.

**2**. In what ways is it anticipated that an outreach service to your school will assist the student and the family?

Click here to enter text.

**3**. Have DET Regional staff been involved with the student?

Yes No Provide details: name and date: Click here to enter text.

**4**. Has a referral to Learning Places Connect been made?

Yes No Provide details: name and date: Click here to enter text.

**5**. Have any suspension or expulsions occurred ? Yes No Please give details.

Click here to enter text.

**6**. Outline the Staged Response the school has taken to help the student and the family

Click here to enter text.

**7.** Outline Whole School Programs and Frameworks - Prevention and Early Intervention – currently in place

Click here to enter text.

**8.** IsSchool Wide Positive Behaviour Support implemented across your school?

Yes No SWPBS Coach name and date of implementation: Click here to enter text.

**\* Please note current Cognitive, and Speech Reports must be submitted with this referral**

**9**. Indicate DET Allied Health officers’ involvement including assessments

Psychologist Speech Pathologist Social Worker

Click here to enter text. Report attached\*

**10**. Indicate referral or assessment by other agencies

DHHS RCH MHS MEDICAL SPECIALIST OTHER

Click here to enter text. Report attached\*

**11**. Has the student had a vision impairment test?

No Yes Please provide details: Details

**12**. Has the student had a hearing impairment test?

No Yes Please provide details: Details

**13**. Is the student receiving support through the Program for Students with Disabilities?

No Yes Funding level and criteria: Details

**14**. Does the student have a Behaviour Support Plan?

No Yes

Details Plan attached

**15**. Does the student have an Individual Education Plan?

No Yes

Details Plan attached

**16**. Does the student have a Mental Health Plan?

No Yes

Click here to enter text. Plan attached

**17**. Does the student have a Student Support Group?

No Yes Please provide details of composition and frequency of meetings:

Click here to enter text.

**18**. Family background (current living arrangements, siblings, custodial agreements).

Click here to enter text.

**19**. List the student's strengths and personal resources.

Click here to enter text.

**20**. Has the student’s attendance been regular? Please provide attendance summary for the last 8 weeks

Click here to enter text.

**21**. Medical history/General health. (Include any medication the student is taking e.g Ritalin, Concerta, Risperdal )

Click here to enter text.

**22**. Is there a medical diagnosis? e.g Autism, ADHD, Oppositional Defiant Disorder.

Click here to enter text.

**23**. Does the student have a formal (multidisciplinary) ASD diagnosis? No Yes

If YES, a Sensory Profile completed by an Occupational Therapist is required with this referral

**24**. Please attach copies of the student’s most recent school and NAPLAN reports.

*I agree that I have received consent in writing from the guardian/carer of the student named in this referral which allows for mutual exchange of information between the above-mentioned school and Yarra Me School. Please use DET template if you do not have a school information exchange form.*

*I agree that the consent received from the parent/carer acknowledges that the authority will remain in place for the duration of the student’s involvement with Yarra Me School and beyond if information exchange is required for the student’s care.*

Referring Teacher’s Name: Click here to enter text.

Position: Signature:

Principal’s Name: Click here to enter text. Signature: .Date:Click here to enter a date.

**SEND COMPLETED REFERRAL**

**FORMS TO:**

**Yarra Me School**

**PO Box 8228, NORTHLAND CENTRE 3072**

[**yarra.me.sch@edumail.vic.gov.au**](mailto:yarra.me.sch@edumail.vic.gov.au)

**FAX: 9478 6686**