**DET new logo**

Web address: [www.yarrame.vic.edu.au](http://www.yarrame.vic.edu.au)

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

ABN: 32 453 166 084

Attach Student Photo

**YARRAME SCHOOL**

**INTAKE PROGRAM**

**STUDENT REFERRAL 2023**

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| **DATE OF REFERRAL** |  |

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| **REFERRING SCHOOL:** |  | | |
| **SCHOOL ADDRESS:** |  | | |
| **PHONE NO:** |  | **EMAIL:** |  |
| **SCHOOL CONTACT:** |  | | |
| **ROLE AT SCHOOL:** |  | **DIRECT NO:** |  |
| **CURRENT CLASSROOM TEACHER/S** | | | |
| **NAME** | | **CONTACT INFORMATION** | |
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| **STUDENT NAME:** |  | | | |
| **2023 YEAR LEVEL:** |  | **DATE OF BIRTH:** |  | |
| **GENDER:** |  | | | |
| **IS THE STUDENT OF ABORIGINAL OR TORRES STRAIT ISLANDER ORIGIN?** | | | |  |
| **HOME ADDRESS:** |  | | | |
| **PARENT/CARER 1:** |  | **DIRECT PH NO:** |  | |
| **RELATIONSHIP:** |  | **EMAIL:** |  | |
| **PARENT/CARER 2:** |  | **DIRECT PH NO:** |  | |
| **RELATIONSHIP:** |  | **EMAIL:** |  | |
| **PREVIOUS SCHOOL:**  **(IF APPLICABLE)** |  | | | |

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| **PROGRAM** |
| YarraMe School provides Social and Emotional Learning Intensive programs that are personalised for each student. This is done in partnership with the referring school using a multidisciplinary intervention approach.  Please see our website [www.yarrame.vic.edu.au](http://www.yarrame.vic.edu.au) for a description of the programs and referral criteria. |

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| **TO BE COMPLETED BY THE REFERRING SCHOOL** | |
| 1. **REASONS FOR REFERRAL.:** | |
| **DESCRIPTION OF CONCERNS SCHOOL / HOME:** |  |
| **IN WHAT WAYS IS IT ANTICIPATED THAT A PLACEMENT IN THE PROGRAM WILL ASSIST THE STUDENT AND THE FAMILY?** |  |

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| 1. **SUPPORTS / AGENCIES:** | | | | | | | | | | | | | |
| Has the student been previously supported by YarraMe School? | | | | | |  | YES | |  | | | | NO |
| **IF YES, PLEASE INDICATE THE PROGRAM(S):** | | | | | | | | | | | | | |
|  | Junior Program |  | Senior Program |  | Inclusion Outreach Service | | |  | | | Secondary Consultation | | |
| Has an IRIS been lodged in relation to this student’s behaviour? | | | | | |  | YES | |  | | | | NO |
| **IF YES, PLEASE PROVIDE DETAILS:** | | |  | | | | | | | | | | |
| Have DE Regional staff been involved with the student? | | | | | |  | YES | | |  | | NO | |
| **IF YES, PLEASE PROVIDE DETAILS (NAME / DATE):** | | |  | | | | | | | | | | |
| Has the student been referred to the Board Certified Behaviour Analyst (BCBA)? | | | | | |  | YES | | |  | | NO | |
| **IF YES, PLEASE PROVIDE DETAILS:**  **\* NAME OF PROFESSIONAL**  **\* COPY OF PLAN:** | | |  | | | | | | | | | | |
| Have any suspension or expulsions occurred? | | | | | |  | YES | | |  | | NO | |
| **IF YES, DETAIL BEHAVIOURAL CONSEQUENCES:** | | |  | | | | | | | | | | |
| **OUTLINE THE STAGED RESPONSE THE SCHOOL HAS TAKEN TO SUPPORT THE STUDENT AND THE FAMILY:** | | |  | | | | | | | | | | |
| IsSchool Wide Positive Behaviour Support (SWPBS) implemented across your school?  If No, what other behaviour frameworks do you have in place? | | | | | |  | YES | | |  | | NO | |
| **SWPBS COACH NAME AND DATE OF IMPLEMENTATION OR BEHAVIOUR PREVENTION FRAMEWORKS USED:** | | |  | | | | | | | | | | |

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| 1. **ASSESSMENTS / PLANS:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Indicate Department of Education / SSS involvement including assessments: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Psychologist | | | | |  | | | | Pediatrician | | | | |  | | Speech Pathologist | | | | | |  | | Occupational Therapist | | | | |
| **OUTLINE THE STRATEGIES SUGGESTED BY DE/SSS STAFF AND THE OUTCOMES**  **\* ATTACH REPORT** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Indicate referral or assessment by other agencies, eg Paediatrician /MHS: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | DFFH | |  | | | RCH | | | | |  | | MHS | | | |  | | Medical Specialist | | | |  | | | Other | | |
| **IF YES TO ANY, PLEASE PROVIDE DETAILS**  **(NAME / DATE):**  **\* ATTACH REPORT** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| Has the student had a vision impairment test? | | | | | | | | | | | | | | | | | | |  | | | YES | | | |  | | NO | |
| **IF YES, DETAILS:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| Has the student had a hearing impairment test? | | | | | | | | | | | | | | | | | | |  | | | YES | | | |  | | NO | |
| **IF YES, DETAILS:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| Is the student receiving support through the Program for Students with Disabilities? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | No | |  | | Yes | | | Level | | | | |  | | | Criteria | | | | |  | | | | | | | | |
| **\*\*\*\*PLEASE NOTE CURRENT COGNITIVE, AND SPEECH REPORTS MUST BE SUBMITTED WITH THIS REFERRAL\*\*\*\*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| 1. **SUPPORT PLANNING:** | | | | | | | | | |
| **IS THE STUDENT ABLE TO PLAY COOPERATIVELY IN THE PLAYGROUND OR DO THEY NEED ADDITIONAL SUPPORT?** |  | | | | | | | | |
| **ARE THERE SPECIAL ARRANGEMENTS IN PLACE TO SUPPORT THIS CHILD’S NEEDS IN THE PLAYGROUND?** |  | | | | | | | | |
| Does the student have a Behaviour Support Plan/Safety Plan? | | |  | | YES | |  | | NO |
| **IF YES, DETAILS:**  **\* ATTACH PLAN** |  | | | | | | | | |
| Does the student have an Individual Learning Plan? | | |  | | YES | |  | | NO |
| **IF YES, DETAILS:**  **\*\* ATTACH PLAN** |  | | | | | | | | |
| Does the student have a Mental Health Plan? | |  | | YES | |  | | NO | |
| **IF YES, DETAILS:**  **\* ATTACH PLAN** |  | | | | | | | | |
| Does the student have a Student Support Group (SSG)? | |  | | YES | |  | | NO | |
| **PLEASE PROVIDE DETAILS OF COMPOSITION AND FREQUENCY OF MEETINGS:** |  | | | | | | | | |

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| 1. **PERSONAL INFORMATION:** | |
| **FAMILY BACKGROUND (CURRENT LIVING ARRANGEMENTS, SIBLINGS, CUSTODIAL AGREEMENTS)** |  |
| **LIST THE STUDENT’S STRENGTHS AND PERSONAL RESOURCES** |  |
| **HAS THE STUDENT’S ATTENDANCE BEEN REGULAR? PLEASE PROVIDE ATTENDANCE SUMMARY FOR THE LAST 8 WEEKS.** |  |

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| 1. **MEDICAL REPORTS:** | | | | | | | |
| **MEDICAL HISTORY /GENERAL HEALTH. (INCLUDE ANY MEDICATION THE STUDENT IS TAKING E.G RITALIN, CONCERTA, RISPERDAL** |  | | | | | | |
| **IS THERE A MEDICAL DIAGNOSIS? E.G ASD, ADHD, ODD, OCD** |  | | | | | | |
| Does the student have a formal (multidisciplinary) ASD diagnosis? | |  | YES |  | | | NO |
| **IF YES, A SENSORY PROFILE COMPLETED BY AN OCCUPATIONAL THERAPIST IS REQUIRED WITH THIS REFERRAL** | | | | | | | |
| Is the student in receipt of NDIS funding? | |  | YES | |  | NO | |

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| 1. **ACADEMIC:** |
| **PLEASE ATTACH COPIES OF STUDENT’S MOST RECENT ACADEMIC REPORTS** |
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*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 YarraMe School. 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 YarraMe School and beyond if information exchange is required for the student’s care.* *An administrative fee of* ***$500 (Ex GST)*** *per referral will be charged to the referring school.*

*I have read and agree with the conditions of the placement as set out* *in* *the* ‘*Partnering Agreement.' See sample agreement on Yarra me School website.*

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| **ROLE** | **POSITION** | **SIGNATURE** |
|  |  |  |
| **PRINCIPAL NAME** | **SIGNATURE** | **DATE** |
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**UPLOAD COMPLETED REFERRAL FORMS TO:**

<https://www.yarrame.vic.edu.au/intake.html>

Selecting either the Junior or Senior Program online form

**NOTE: Please complete the Referral Checklist on the next page before lodging the referral form**

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| **Section** | **Documentation Required with Intake Referral** |
| **Referral Form** | All sections are completed |
| **Cognitive/WISC Assessment** | Complete Cognitive Report |
| Current (less than 2 years) is attached |
| **Speech and Language Assessment** | Complete Speech and Language Report  Current (less than 2 years) is attached |
| **ASD**  **Sensory Profile** | Sensory Profile Report by Occupational Therapist is  attached. This is a requirement for students with a  formal ASD diagnosis |
| **Other assessments** | If other assessments are indicated, the reports must be  included e.g medical specialist |
| **Attendance** | An 8 week attendance summary is included |
| **Custodial Arrangements** | Copy of any custodial arrangements or intervention  orders attached |
| **Signature** | Principal has signed, and agreed to the conditions in  the *Partnering Agreement* |
|  | **Please make sure you include all of the required documentation**  **\*\*Referrals lodged without the above documentation cannot be processed\*\*** |
|  | **OFFICE USE ONLY** |
|  | All sections are complete and reports included |
|  | Was the student supported in Sec. Consult, Intake or  Inclusion Support? When?  If yes, file history downloaded and attached. |
|  | Date referral received: |