Stanislaus County
Office of Education

Child/Family Services

Tom Changnon, Superintendent
1100 H Street • Modesto, CA 95354 • (209) 238-1800 • FAX (209) 238-4217

CHILD/FAMILY SERVICES
CHILD SUCCESS TEAM REQUEST

Identifying Information

Service Options: ____Center Based ____Home Based ____FCCH ❑ Full Day ❑ AM ❑ PM

____EHS ____RHS ____MHS

Location_________________ Teacher/Home Visitor_________________ Enrollment Date _____________

Child's Name____ M_____ F_____ DOB______________

Parent/Guardian____ Phone____________________

Address____ City_________________ ZIP________

District of Residence__________________________________ Primary Language_________________

(If Unknown, Leave Blank)

Contact Made

Parent/Guardian____ Date__________________

Delegate Coordinator/Site Supervisor__________________________________ Date __________________

Other____ Date __________________

Screening Results

Vision ___________ Hearing ___________ Speech/Language___________ Developmental ___________

Referral Area of Concern

☐ Health/Medical ☐ Speech/Language ☐ Cognitive ☐ Other ____________________

☐ Developmental ☐ Gross Motor ☐ Fine Motor ☐ Self Help

☐ Behavioral/Social/Emotional (Date individual mental health observation requested: ____________________)

Completed ❑ Yes ❑ No

Describe specific reasons for referral ____

____

____

____

Describe pre-referral interventions used (include environmental modifications) and results________________

____

____

☐ Itinerant Teacher Support needed. Type of support requested: ___________________________________

Describe child's strengths____

____

Participants

☐ Level 1
Classroom Staff

☐ Level 2
Classroom Staff,
Site Supervisor

☐ Level 3
Classroom Staff,
Disability Supervisor

☐ Level 4
Classroom Staff,
Site Supervisor Consultant

Submitted by:____ **Date:**____________________

Phone:____

Distribution: White - Grantee Disabilities Supervisor Yellow - Child/Family File Pink - Parent
White - Delegate Disabilities Coordinator (MHS)