THE SCHOOL DISTRICT OF ESCAMBIA COUNTY
Exceptional Student Education
30 E. Texar Drive, Pensacola, FL 32503
Phone: (850) 432-6121

LAKEVIEW CENTER OUTPATIENT SERVICES ESE REFERRAL FORM

STUDENT DATA

STUDENT LEGAL NAME: _____ GRADE: _____

SCHOOL: _____ RACE: _____ SEX: _____ VERIFIED BIRTHDATE: _____

COUNTY #- _____ STUDENT'S PRIMARY LANGUAGE: ☐ English ☐ Other

STUDENT'S ADDRESS: _____ PHONE: _____
Street City Zip Code

Exceptional Student Education programs for which the student is eligible: _____

PARENT DATA

FATHER'S NAME ADDRESS WORK PHONE

MOTHER'S NAME ADDRESS WORK PHONE

GUARDIAN'S NAME ADDRESS WORK PHONE

I give my permission for the School District of Escambia County to release information concerning my child to Lakeview Center and to receive information from them regarding this referral.

Parent Signature: _____ Date: _____

REASON FOR REFERRAL TO LAKEVIEW CENTER

_____

_____

_____

_____

_____

_____

_____

☐ School Day Support Services ☐ Navigator Program

The following documentation supporting the referral is attached:

☐ Current Psychological Report ☐ Medical Information ☐ Other _____
Please Specify

☐ Observations ☐ Interventions

☐ Anecdotal Note ☐ School Counselor's Report

REFERRAL APPROVAL

Principal/Designee: _____ Date: _____

Program Representative: _____ Date: _____

ESE Director/Designee: _____ Date. _____

Distribution: Lakeview Center; Cumulative Folder, Central Files, Parent
9300-ESE-046 Revised: 07-02-12