Telarah Public School

Phone: (02) 4933 6532
Fax: (02) 4934 3039

Learning Support Team

Parent/Caregiver Referral

Date:	___/___/______

LST use only-

Date of Review:	___/___/______
Code:	___ __________

Student Name:			Year	
D.O.B.:	____/____/______	Age:	Class:	
Parent/Caregiver Name:				
Address:				
			P/C:	
Phone:	H	W	M	

Concern Category (please tick):					
	Behaviour		Learning Difficulties		Communication Issues
	Medical Issues		Gifted and Talented		Family Issues
	Hearing/Vision Impaired		Physical Problem		Emotional
	Social Problems		Other-		

Reasons for your concern: ____
____
____
____
____

I would like to suggest the following take place: ____________________________
____
____

Programs or intervention previously implemented (at other schools or Maitland Public School): ____
____
____

Signed: ________________________ Name: ______________________________
Relationship to Student: ________________

I give permission for the school counsellor to:

1. Carry out assessment and counselling as required YES/NO
2. Contact the authors of the reports I have provided from the following agencies
   ____ YES/NO
3. Exchange information with these agencies YES/NO

Parent /Caregiver's signature: ______________________ Date: ___/___/______