**ENTERPRISE CENTRE REFERRAL**

Please indicate where this student will be attending:

On Site – at the Enterprise Centre

Satellite – remotely at home school

*Date:* Click or tap to enter a date.

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| **STUDENT INFORMATION** | | | | | | | | |
| **Student Full Name**: | | | | | | | | |
| **Student Preferred Pronouns: (Ex. he/him, she/her, they/them):** | | | | | | | | |
| **Date of Birth**: Select Month Select Day, Select Year | | | | **Student Number**: | | | | |
| **Student Address**: | | | | | | | | |
| **Student Email**: | | | | **Student Phone Number**: | | | | |
| **School**: | | | | **Referring ESST member**: | | | | |
| **Parent(s) / Guardian(s)**: | | | | | | | | |
| **Address**: | | | | | | | | |
| **Phone** (Home): | | | (Work): | | | (Cell): | | |
| **Is this student currently living at home?** Yes No  **Does this student have a computer and internet access at home?** ☐Yes ☐No | | | | | | | | |
| **Is this student currently attending classes?**  Yes  No  If no, please provide last date of attendance: | | | | **ELPA Status**:  Pass  Incomplete  Exempt | | | | |
| **AREA(S) OF CONCERN:** | | | | | | | | |
| Academic | Social | Emotional Health | | | Behaviour | | Attendance | Physical Health |
| Please provide a **detailed** description of the area(s) of concern and interventions implemented to date:  Are the parent(s)/guardian(s) aware of the referral? Yes  No  Do the student’s parent(s)/guardian(s) share your concerns? Yes  No | | | | | | | | |
| **CURRENT SUPPORT**  **All pertinent documentation related to this referral has been uploaded to the student’s electronic folder** Yes No | | | | | | | | |
| **Please indicate a contact name for each checked item** | | | | | | | | |
| Child and Youth Team Name:  EST-Guidance Name:  SIW  SLP Name: | | | | EST-Resource Name:  APSEA Name:  Educational Assistant  District Support Name: | | | | |
| **Other services/agencies involved with student (Please indicate a contact name for each checked item):** | | | | | | | | |
| OT Name:  PT Name:  Medical Doctor Name:  Mental Health Name: | | | | Addictions Name:  Social Development Name:  Transition Housing Location:  Public Safety Name: | | | | |
| Other: | | | | | | | | |
| **EDUCATION PLAN** | | | | | | | | |
| **Academics:** | | | | **Behaviour:** | | | | |
| PLP-ACC PLP-ADJ PLP-IND | | | | PLP-IBSP BSAP  Other (VTRA, Suicide Intervention Plan) | | | | |

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| Please email this form to:   * **Iona Brown** – Alternative Programs Coordinator[iona.brown@nbed.nb.ca](mailto:iona.brown@nbed.nb.ca) * *CC* the following:   **Erin Gibbs – Enterprise EST-Guidance** [erin.gibbs@nbed.nb.ca](mailto:erin.gibbs@nbed.nb.ca) |