Center for Spectrum Services
School District / Agency Referral Form

School District/Agency: ________________________________ Date: ____________________

Name of Person Referring: ______________________________ Position: ________________

Phone: ____________________ Email Address: ______________________________________

Type of Service Requested: __________ Student Consultation ______ Workshop/Training ___ Training

______Diagnostic Evaluation __________ Social Skills Group _____ Individual Counseling

______ Triennial Evaluation _________ Augmentative Communication Evaluation

Other: ____

Student Information: (Complete when appropriate)

Name: _______________________________________ DOB: __________ CA: ___________

Parent /Guardian: ____________________________________ Phone: __________________

Address: ____

Name of School: ____

Current Educational Program: ____

Reason for Referral: ____

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School District / Agency agrees to pay $ __________ for services rendered: ____Yes ___No

______ Yes, with the following specifications: ____

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Authorizing Signature: _________________________________ Date: _______________

Title: ____

Mail to: Cheryl N. Engel, Ph.D.
Center for Spectrum Services
70 Kukuk Lane
Kingston, NY 12401

or Fax to: (845) 336-4153
Attn: Dr. Cheryl Engel