REFERRAL/INTAKE
CSKT TRIBAL EDUCATION DEPARTMENT

PO Box 278
Pablo, MT 59855
(406) 675-2700

REFERRAL FROM: ____

Name **School/Agency**

____

Phone Number **Email** **Date**

Parent/Guardian Name(s): ______________________________
Parent/Guardian Phone Number(s): ______________________________
Parent/Guardian Physical Address: ______________________________
Parent/Guardian Mailing Address: ______________________________

Emergency Contact Name: ______________________________
Emergency Contact Phone Number(s): ______________________________

Child(ren) Name(s):	DOB	School	Grade	Gender	Tribal Affiliation

What is the reason for referral? ______________________________
How has the school attempted to address the issue? ______________________________

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If an attendance issue, **how many days missed out of total school days:** ____________/____________

Days Missed Total School Days

Additional Comments: ______________________________

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CSKT TRIBAL EDUCATION DEPARTMENT ONLY

Date Received by TED: ______________________________
TED Staff: ______________________________
Initial contact date with family: ______________________________
Date of Transfer: ______________________________
Transferred to: ______________________________