Greta B. Johnston
Coordinator, Mental Health

Daniel T. White
District Superintendent

FLECS REFERRAL JUSTIFICATION FORM

Student: ______________________ **DOB:** ______________________
Parent(s) Name: ______________________ **District:** ______________________
Phone: ______________________ **Program:** ______________________
Address: ____

Reason for Referral (Please write a brief description of your concerns about this student, including relevant background information):

Is the student (or other family members) receiving counseling services by other professionals in the community? If yes, please describe:

Referring Person: ______________________ **Title**: ______________________

District Administrator signature indicating support of this request:

Print Name: ______________________ **Signature:** ______________________

FLECS Hours Recommended: ____________

Once this form is completed, please forward to the home district. If service is approved, home district is to attach this to the* ***Request for Support Services Form* ***and forward the entire packet to the Monroe #1 BOCES Behavioral Health Office.***