North Carolina Department of Health and Human Services
Wright School
3132 North Roxboro Street - Durham, North Carolina 27704
State Courier 17-27-04 • Fax: (919) 560-5795 • Phone: (919) 560-5790
www.wrightschool.org

To: Wright School Admission Committee

From: Qualified Professional or Local Contact: ______________________________

Mailing Address: ______________________________

Phone: ______________ Fax: ______________ E-mail Address: ______________________

Referral for: ______________________________ Date of Birth: ______________

Date of Referral: ______________

SUPPORTING DOCUMENTATION

- ☐ HIPAA-Compliant Consent to Exchange Information Form
- ☐ MCO Care Review Team Signature Form with Recommendations
- ☐ Psycho-Educational Testing: IQ (within 3 years) and Academic Achievement
- ☐ Exceptional Children school records, including all DEC forms and IEPs (if applicable)
- ☐ Clinical Admission Assessment (if applicable)
- ☐ Person Centered Plan (if applicable)
- ☐ Social History
- ☐ Immunization Records
- ☐ Psychiatric Assessment (if available)
- ☐ Discharge Summaries from Psychiatric Hospitalizations (if applicable)
- ☐ Discharge Summaries from prior residential placements (if applicable)
- ☐ DSS reports (if applicable)
- ☐ Juvenile Court Records (if applicable)
- ☐ Neurological testing (if applicable)
- ☐ Speech/Language Evaluation (if applicable)

MCO AUTHORIZATION SIGNATURES

Name of MCO: ______________________________

Care Review Chair: ______________________________ ______________________________
Signature Print Name

SOC Clinical Coordinator/Director (or Designee): ______________________ ______________________
Signature Print Name

Name of Assigned Care Coordinator: ______________________________

Phone: ______________________ Email: ______________________________

Wright School
Referring Information for Admission

Child's Name: ______________________________________ Race: _______ DOB: _______ Sex: _______

County of Residence: _____________________________

Parent/Guardian Name: ___________________________________

Relationship to Child: _____________________________________

Parent/Guardian Address: ____

Parent/Guardian Phone #(s): Home: _________________ Work: _________________ Cell: __________________

Parent/Guardian Email Address: ____________________________________

How does the parent/guardian prefer to be contacted? Home phone Work phone Cell phone Email

Family members currently living in home with child: ____

Strengths:
Interests:
Triggers:
Academic Skill Deficits:
Home/Community Troubling Behaviors:
Diagnoses:
Medications:

Behavioral Strategies/Mental Health Interventions	Effectiveness (Describe)

Describe the following:

Allergies	
Runaway attempts	
Firesetting	
Sexualized behaviors	
Special medical needs	
Bedwetting (day/night/frequency)	
Traumatic events in history	

School: ____ Grade: ____________________

Academic Skills Deficit(s): ____

If EC Classified:

Special Education Classification:	Setting:
IEP Expiration Date:	

Most current cognitive testing results – WISC-IV

Verbal comprehension: ____________ Perceptual reasoning: _____________ Working memory: ____________

Processing speed: ____________ Full scale: _____________

Troubling School Behaviors	School Behavioral Interventions

Contact Information

Mental Health Professional	Name	
	Agency	
	Address	
	Work Phone	
	Email	
DSS Worker (if applicable)	Name	
	Agency	
	Address	
	Work Phone	
	Email	
Guardian Ad Litem (if applicable)	Name	
	Agency	
	Address	
	Work Phone	
	Email	

Court Counselor (if applicable)	Name	
	Agency	
	Address	
	Work Phone	
	Email	
Other Professional involved (if applicable)	Name	
	Agency	
	Address	
	Work Phone	
	Email	