The Kahala Clinic for Children & Family

School Referral Information

Name: _____ Phone: _____

Position: _____ E-mail: _____

Consent: Circle One: Y N School: _____

Student Information

Name: _____ Grade: _____

Date of Birth: _____ Parent name: _____

Gender:: _____ Parent phone: _____

Reason for Referral

_____

_____

_____

_____

_____

Interventions

☐Preferential Seating
☐1:1 Assistance
☐Chunking
☐Reduced Workload
☐Tutoring
☐Medication

☐Daily Behavior Log (attach)
☐Behavior Plan (attach)
☐Assistive Technology (describe):
_____
_____
☐ _____

** PARENT NEEDS TO CONTACT OUR OFFICE DIRECTLY TO REQUEST AN INITIAL CONSULTATION.. PLEASE ATTACH RELEASE OF INFORMATION CONSENT FORM IF AVAILABLE.

KAHALA OFFICE BUILDING SUITE 208, 4211 WAIALAE AVE, HONOLULU, HI 96816
PH: 808.888-5228 FAX: 808..732.6433 WEB: www.kahalaclinic.org