Kent ISD Traumatic Brain Injury Transition Team (T.B.I.T.T.)
REFERRAL FORM

TO MAINTAIN ACCURACY, PLEASE SUBMIT FORM ELECTRONICALLY. NO HANDWRITTEN COPIES.

Fax: 616-447-2440
Email: cariedrake@kentisd.org

Date of Referral: _____ Name: _____

Date of Birth: _____ Parent Guardian: _____

Address: _____
Street City State Zip

Phone: _____ School District/Building: _____ Grade: _____

Referral Source:

Name: _____ Phone: _____

Address: _____

Medical Information:

Treatment Facility: _____

Physician: _____

Date of Injury: _____ Date of Discharge: _____

Diagnosis: _____

Mechanism of Injury: _____

Precautions: _____

Anticipated Date of Return to School: _____

Areas of Concern: (Current Level)

Physical Symptoms: _____

_____

Motor Functioning: _____

_____

Speech & Language: _____

_____

Cognitive: _____

_____

Behavioral: _____

_____

Social/Emotional: _____

_____

Current Services:

_____

_____

FOR KENT ISD USE ONLY

To be completed by Carie:

Sent to T.B.I.T.T.: _____ Date: _____
Team Member

Form Placed in CA60 by: _____ Date: _____
Team Member

Rev. 10/18