



Lowndes County
Board of Education Head Start



INTERNAL REFERRAL/FOLLOW-UP FORMSOCSER622

Child's Name _____ Date of Birth _____

Center _____ Date _____

From:

- Teacher
- Teacher's Aide
- Family Service Worker

To:

- Social Services
- Education
- Health
- Disabilities
- Nutrition
- Mental Health
- Parent Involvement

Part II Referral

Description of Problem

Absentee Health Related Late Pickup Observation Needed

Other

Describe the problem (be specific): _____

Part III Follow-up

Status of Referral

Being handled Additional Follow-up Needed Problem Resolved

Describe action taken (be specific): _____

Additional comments: _____

Follow-up completed by: _____ Date _____