WEBER SCHOOL DISTRICT SUBSTANCE ABUSE SCREENING REFERRAL
AGENCY: WEBER HUMAN SERVICES

Mail or fax the completed form to Weber Human Services (in care of: Specialized Family Services Team). To make an appointment, call 801-625-3738.

237 26th Street
Ogden UT 84401
Fax 801-778-6817

Today's Date: ________________________
Appointment Date: ____________________
Appointment Time: ____________________

(has been referred) / (voluntarily agreed) to obtain a drug/alcohol assessment and, if deemed appropriate, services.

Reason for referral: ____________________________________________________________

School Administrator's Information:

Name: (Please Print) _________________________ School: ____________________________
E-mail: ___________________________ Phone: __________________________ Fax: __________________________
Signature: ____________________________

CONSENT TO RELEASE INFORMATION

I, ____________________________, having been informed concerning the current Federal Confidentiality Regulations, hereby consent to the release of the screening information to:  Weber School District Officials

I, voluntarily allow Weber Human Services to disclose the following recommendations. No threat or other coercive measures have induced me to sign this consent. I understand that this information will not be forwarded to anyone other than those persons with whom I am working in the school and/or the district Student Services Office without my written permission. I may revoke this Consent to Release Information at any time, with written notice. If I do not revoke it earlier, this document will be null and void on: ________________________

Student: ___________________________ Date: ____________
Parent/Guardian: ______________________ Date: ____________
Staff Member/Witness: ________________ Date: ____________

NOTIFICATION OF FINDINGS AND RECOMMENDATIONS:

SCREENING SUMMARY:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

RECOMMENDATIONS:
☐ Parent Teen Alternative School ________________
☐ Drug and Alcohol Counseling ________________

Other (Specify) __________________________

Date services will begin: ____________________
Evaluator: ___________________________ Date: ____________________

DISTRIBUTION - Weber Human Services will provide a copy of this completed form to the following: the referring school official, the student, the parents, and district Student Services.

*Weber School District will pay for the Parent Teen Alternative School Educational Program. Any counseling services would be at the family's discretion and their financial responsibility.