

TEAM (Teens Engaged as Mentors)

Mentee Referral 2016-2017

Name: Age:

School: Grade of child (in Sept. 2016):

Primary Contact:

Phone:

Email:

**The following questions are all optional and are meant to give us an idea of how we can best support this child in their success with TEAM.**

1. Does this child have a diagnosed disability?
2. What are his/her strengths:
3. Does he/she receive any therapies or services? Please list.

**Interests:**

What activities does he/she most enjoy?

What activities does he/she least enjoy?

What are the best ways to communicate with/deescalate the child?

**Behavior:**

Does he/she have any challenging behaviors that we should be aware of?

If so, what is likely to trigger these behaviors? (ex: change in schedule; noise, etc)

How does he/she express being upset? Overwhelmed? Frustrated?

What are some things that are calming?

**Goals:**

What do you hope to see him/her accomplish through TEAM?

Is there anything else you would like us to know?

**Parent/Guardian Contact Info**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Relationship: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone: |  | Email: |  |

|  |  |
| --- | --- |
| Signature/Consent to Participate: |  |

PLEASE EMAIL COMPLETED FORMS to [autismprogram@bmc.org](mailto:autismprogram@bmc.org)

OR mail to: The Autism Program at Boston Medical Center

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