STUDENT ASSISTANCE TEAM REFERRAL FORM

Student's Name: _____ **Grade:** _____

Referring Teacher: _____ **Date:** _____

Background Information

Is there a history of excessive absences? _____ If yes, total absences _____ total tardies _____

Has the student been retained? _____ If yes, what year(s)? _____

Most recent vision exam – date _____ Results _____

Most recent hearing exam – date _____ Results _____

Does the student wear glasses? _____

Academic Data

MEAP Scores _____

GLAD Scores _____

DIBELS Scores _____

AIMS Web _____

Grades as of _____ (date)

Reading _____ Writing _____ Social Studies _____

Science _____ Math _____

Academic Strengths and Weaknesses

Please check the box that best indicates your perception of the student's skills in each area compared to the rest of your class.

	Bottom 10% of My Class	Between the Bottom 10% and Bottom 30% of My Class	Skills are Higher than the Bottom 30% of my Class
Basic Reading Skills			
Reading Fluency			
Reading Comprehension			
Mathematics Calculations			
Mathematical Problem-Solving			
Written Expression			
Oral Expression			
Listening Comprehension			

General Areas of Concern (check each that apply and briefly describe)

- Inattention _____
- Organization _____
- Behavior _____
- Emotional _____
- Reading _____
- Math _____
- Writing _____
- Communication _____

Data Related to Area of Major Concern (provide specific data – i.e. test scores, % of homework completed, # of prompts required to initiate a task, # of behavioral referrals, etc.)

_____

_____

_____

_____

_____

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_____

Strategies Utilized (extra practice, changing seating, changing task size, extended time, tutoring, etc.)

Strategy Attempted	Duration (start and end date)	Results (include specific data)