

CHILD STUDY TEAM

Student Referral Form

Blue Mountain School District
Orwigsburg, Pennsylvania

Student Name	Birth Date
Parent/Guardian	Telephone
Address	
Teacher	Referral Date

Reason for Referral: (Describe the presenting problem and attach work samples)

What tasks would you like to see the student be able to do that he/she is not presently doing?

STUDENT STRENGTHS

STUDENT NEEDS

(include subject areas, task oriented activities, task completion, personality qualities, pro-social skills)

--	--

What have you learned from parent contacts? Be specific.

Have you contacted last year's teacher?

Yes

No

Based on your observations, please evaluate the student in comparison to other students in the same grade, by checking problems THAT OCCUR FREQUENTLY.

MEMORY

- Difficulty remembering what is seen
- Difficulty remembering what is heard
- Difficulty retaining information over a period of time

SOCIAL/EMOTIONAL

- Lacks motivation
- Lacks self-control
- Easily frustrated
- Sudden mood changes during the day
- Inconsistent performance
- Needs constant approval
- Interrupts/distracts class
- Unusually aggressive towards others
- Unusually shy or withdrawn
- Difficulty interpreting social cues
- Difficulty making and keeping friends
- Doesn't accept responsibility for own behavior
- Cries frequently
- Easily influenced by others

DISCRIMINATION

- Difficulty discriminating letter symbols
- Difficulty discriminating letter sounds

ORAL EXPRESSION

- Difficulty expressing thoughts and ideas
- Limited speaking vocabulary

VISUAL MOTOR COORDINATION

- Difficulty with small motor tasks
- Difficulty with paper and pencil tasks
- Difficulty copying from the board

ATTENTION/ORGANIZATION/ACTIVITY

- Difficulty beginning a task
- Difficulty maintaining attention
- Easily distracted
- Loses/forgets work and materials
- Difficulty with organization
- Difficulty completing tasks
- Difficulty with changes in routine
- Overactive
- Underactive

SPEECH

- Stutters
- Difficulty articulating speech sounds
- Unusual voice quality

LISTENING COMPREHENSION

- Difficulty understanding spoken language
- Difficulty following verbal directions

READING

- Difficulty with decoding of words and basic reading skills
- Difficulty with comprehension
 - Unable to:
 - identify details
 - sequence
 - identify main ideas
 - predict
 - recognize cause and effect

WRITTEN EXPRESSION

- Difficulty with spelling
- Difficulty with completing written tasks quickly
- Difficulty with punctuation/capitalization
- Difficulty with grammar and usage
- Difficulty using appropriate vocabulary
- Difficulty organizing thoughts at the:
 - simple sentence structure
 - paragraph level
- Difficulty with sentence structure and variety

MATHEMATICS

- Difficulty with number recognition
- Difficulty with number concepts
- Difficulty with basic operations:
 - addition
 - subtraction
 - multiplication
 - division
- Difficulty understanding place value
- Difficulty solving word problems
- Difficulty with decimals
- Difficulty with fractions

Identify the area where the student is achieving below average grades:

- English
- Math
- Reading
- Science
- Social Studies
- Other

ANY ADDITIONAL COMMENTS/ INFORMATION:

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Student has previously been retained. Grade(s) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Student has been through CST process in the past. Grade(s) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Student receives speech and language services. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Student receives remedial reading services. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Student receives ESL services. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Student has undergone psychological testing.
Testing Date: |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Student receives special education services.
Explain |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Student has attendance issues.
Total days absent to date
Explain |

MEDICAL INFORMATION

Please obtain this information from the school nurse.

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Student passed vision screening.
Comments: |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Student passed hearing screening.
Comments: |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Student has medical issues.
Explain: |

INTERVENTIONS ATTEMPTED – List ONLY the adaptations UNIQUE to the student referred

Please indicate every intervention you have tried, listing the subject area where the interventions take place, dates (starting and ending point), frequency (how often), duration (how long) and the effectiveness or outcome.

INTERVENTION ATTEMPTED FOR THAT PARTICULAR STUDENT	SUBJECT AREA	DATE INITIATED	FREQUENCY	DURATION	EFFECTIVENESS