Date Received by CST for Initial Review: _____ /___Teacher Referral ___Parent Referral

Department of Special Services
Glassboro Public Schools
Glassboro, New Jersey

CHILD STUDY TEAM REFERRAL FORM (Preschool)
All Information must be completed

IDENTIFYING INFORMATION
(This should be obtained from the current Emergency Card on file in the Nurse's Office.)

Name_____ D.O.B._____ Age_____ Sex_____

School_____Grade___ Teacher(s)_____Days Absent___ Tardy___

Mother's Name_____ Father's Name_____
Address_____ Address_____
_____ _____
Telephone_____ Telephone_____
Email_____ Email_____
Emergency Name/Telephone_____

CURRENT SUPPORTIVE SERVICES
(Please check the services that the student is currently receiving. Attach progress summary from **EACH** provider.)

Y N PIRT **(If this is a teacher referral and you have not referred this student to PIRT for support, you may begin that process first)**
Y N PIRT Initial Meeting Date :_____(Attach paperwork)
Y N PIRT Follow-up meeting Date: _____ (Attach paperwork)
Y N School Counselor ___Regularly ___As needed
Y N 504 Plan in place

Check all that apply:
Y N Consultation with…. _____CST ____Special Education Teacher _____Behavior Specialist

Specify Outcome: _____

SCHOOL HISTORY
Y N Has the student recently transferred to Glassboro? Date:_____ From:_____

Y N Has the student received services from Early Intervention? If yes, please explain:
_____

_____

Y N Has the student repeated any grades? Which grades?_____

Y N Has the student been referred to the Child Study Team? When?_____
Outcome?_____

Y N Has the student been evaluated by a Child Study Team? When?_____
Outcome?_____

CST Referral Form/Student Name:_____

HEALTH INFORMATION SUMMARY

	Date	Findings
Vision	_____	_____
Hearing	_____	_____

Specific Health Problems/Current Medications (explain any physical symptoms that may impede participation in school activities.):

_____

_____

Physical Symptoms
(Check all that apply)

- ☐ Underweight
- ☐ Overweight
- ☐ Frequently hungry
- ☐ Impaired vision
- ☐ Impaired hearing
- ☐ Appears anxious
- ☐ Frequently uses bathroom
- ☐ Allergies (i.e.…peanut butter)
- ☐ Seasonal Allergies (i.e.…pollen)
- ☐ Frequent physical injuries
- ☐ Deteriorating hygiene
- ☐ Gross Motor Concerns
- ☐ Fine Motor Concerns
- ☐ Speech intelligibility concerns
- ☐ Appears sleepy, lethargic
- ☐ Sleep concerns
- ☐

Background Information (Indicate any concerns outside of school.)

_____

_____

Y N Involvement with outside social service agencies such as DCP&P/DYFS?
If **Yes**, please explain: _____

Is the student receiving any private service(s), such as, Speech, OT, PT, and Counseling?
Please explain:_____

Positive Qualities:
List 1-3 (or more) skills or other positive characteristics and strengths, both personal (e.g., talents, traits, interests, and hobbies) and environments (e.g., friends, family members, faith community) that you have observed or that apply to this student.

_____

_____

_____

_____

_____

_____

CST Referral Form/Student Name:_____

Basis for Referral

Academic concerns: (must be completed for all referrals)

_____
_____
_____
_____
_____

Was a Battelle Developmental Inventory screening completed? If so, when?_____
Please complete below based on screening scores:

Adaptive	Pass/Refer
Personal/Social	Pass/Refer
Communication	Pass/Refer
Motor	Pass/Refer
Cognitive	Pass/Refer

Classroom Functioning:

___ Short attention span/easily distracted
___Difficulty following multi-step directions
___Difficulty imitating modeled behaviors
___Prefers to be alone
___Gives up easily
___Difficulty following one step directions
___Difficulty expressing needs and wants
___Difficulty following classroom routines
___Limited peer interactions
___Is easily frustrated

Adaptive Skill Concerns:

___Difficulty unpack/pack belongings
___Difficulty dressing/undressing
___Is not toilet trained
___Difficulty transitioning
___Difficulty using utensils to feed her/himself
___Difficulty using zippers/buttons
___Difficulty using bathroom independently
___Becomes easily upset/hard to console

Personal-Social Concerns:

___Limited social engagement
___Does not use adults as resources
___Does not respond to praise
___Difficulty waiting his/her turn
___Limited social interactions with adults
___Limited social interactions with peers
___Limited social skills with peers
___Difficulty sharing items with peers

Communication Concerns:

___Limited reciprocity
___Unable to communicate needs/wants
___Limited vocalizations during play
___Unable to use 2-3 word utterances
___Limited use of language to relate information
___Unable to attend to speaker
___Unable to respond to yes/no questions
___Unable to follow simple verbal directions
___Unable to respond to "wh" questions
___ Unable to converse in a turn taking manner

CST Referral Form/Student Name:_____

Motor Concerns:

___Poor Balance
___Unable to run without falling
___Difficulty with jumping
___Difficulty using school tools
___Difficulty with using two hands together
____Presents as clumsy/falls often
____Unable to use stairs without assistance
____ Limited ball skills (throwing/catching/kicking)
____Difficulty with pre-writing stokes (lines/circles)
____Does not have hand dominance

Cognitive Concerns:

___Cannot attend to a story
___Difficulty completing a simple puzzle
___Unable to name basic colors
___Unable to match by shape
___Unable to label and identify shapes
___Cannot point/label pictures in a book
___Unable to match by color
___Unable to label and identify colors
___Unable to name basic shapes
___Doesn't distinguish between numbers/ letters

Prior Academic Intervention Checklist

Directions: Please place an "X" before Modifcation/Accommodation listed below that you have utilized. Provide the start/end dates, number of times used per week and rate its effectiveness on a scale of 1-5 (five being the most effective).

	CLASSROOM FUNCTIONING ACCOMMODATIONS/MODIFICATIONS-----	**Beginning to End Date Strategy Utilized**	**Times Used Per Week**	**Effectiveness Rating**
	Preferential Seating (ex. away from distractions)			
	Break task down into smaller increments			
	Model tasks step by step			
	Provide model of completed tasks			
	Provide a classroom buddy			
	Provide clear and concise classroom expectations			
	Facilitate social interactions			
	Use of individual picture schedule			
	Review and reinforce classroom rules			
	Modify material based on student's ability level			
	Frequently ask questions to engage student			
	Use of fidgets to enhance attention			
	Use of sensory based interventions/supports			
	Others:			
	--ADAPTIVE SKILLS ACCOMMODATIONS/MODIFICATIONS---	**Beginning to End Date Strategy Utilized**	**Times Used Per Week**	**Effectiveness Rating**
	Use of picture checklists for classroom routines			
	Use of visual supports for self-help skills/routines			
	Use of timers to cue transitions			
	Use of if/then card			
	Use of adaptive utensils for eating			
	Use of adaptive tools for fasteners/zippers			
	Use of backward chaining to teach multi-step routines			

CST Referral Form/Student Name:_____

	Others:			
	---PERSONAL-SOCIAL ACCOMMODATIONS/MODIFICATIONS---	**Beginning to End Date Strategy Utilized**	**Times Used Per Week**	**Effectiveness Rating**
	Systematically teach social skills			
	Facilitate, model, and reinforce social skills			
	Encourage social interactions through play			
	Withhold assistance so child must ask for help			
	Provide a daily classroom buddy			
	Review and reinforce classroom rules and positive social behaviors			
	Others:			
	---COMMUNICATION ACCOMMODATIONS/MODIFICATIONS---	**Beginning to End Date Strategy Utilized**	**Times Used Per Week**	**Effectiveness Rating**
	Provide clear and concise directions			
	Frequently check for understanding			
	Supplement verbal language with visual supports			
	Provide modeling and guided instruction			
	Allow for non-verbal responses			
	Model language expectations			
	Script language			
	Use pictures for choice making behaviors			
	Provide extra processing time			
	Others:			
	---MOTOR ACCOMMODATIONS/MODIFICATIONS---	**Beginning to End Date Strategy Utilized**	**Times Used Per Week**	**Effectiveness Rating**
	Use of adaptive scissors			
	Use of different types of grips/pencils/crayons			
	Provide strengthening activities			
	Adapt classroom environment			
	Provide hand over hand guidance			
	Provide visual models/visual supports			
	Use multi-sensory presentation of material			
	Limit multi-sensory presentation of material			
	Others:			
	---COGNITIVE ACCOMMODATIONS/MODIFICATIONS---	**Beginning to End Date Strategy Utilized**	**Times Used Per Week**	**Effectiveness Rating**
	Modify length of activities/tasks			
	Limit amount of information presented			
	Use of drill and repetition to teach skills			
	Plan for maintenance of skills acquired			
	Use of mnemonic strategies			

CST Referral Form/Student Name:_____

	Use multisensory presentation of material			
	Pre-teach new vocabulary			
	Use of visual aids to support instruction			
	Provide small group instruction			
	Provide individualized instruction			
	Utilize peer teaching			
	Others:			

Behavioral and Social Concerns:

Y N Does the student present with Behavior Concerns? If so please specify.
(Must attach copies of behavior reports and individualized behavior intervention plan)

_____
_____
_____
_____

Directions: Please place an "X" before each behavior or action listed below that you have observed. Remember, only behaviors or actions you have observed should be noted.

Disruptive Behavior

___Defiance, violation of rules
___Argumentative
___Cries easily
___Physically aggressive
___Sudden outbursts of anger
___Other:_____
___Obscene language, gestures
___ Noisy, boisterous at inappropriate times
___ Lack of impulse control
___ Highly active
___Inconsistent behavior patterns

Social Behavior

___Tends to be withdrawn
___Lack of peer relationships
___Appears lonely
___Difficulty making friends
___Disrupts other students learning environment
___Appears rigid and/or stubborn on positions
___Unaware of close proximity to peers or staff
___ Other social behavior of concern: _____
___Disrespects or defies authority
___ Attention seeking behaviors
___ Frequently ridiculed by classmates
___ Appears unhappy/sad
___ Has difficulty in unstructured settings
___ Sensory concerns: Define_____
___ Demonstrates a lack of self-confidence

If you have checked any item under the *Social Skills* or *Disruptive Behavior* sections, please attach another piece of paper and provide a detailed explanation.

Prior Social/Behavioral Intervention Checklist

Directions: Please place an "X" before Modification/Accommodation listed below that you have utilized. Provide the start/end dates, number of times used per week and rate its effectiveness on a scale of 1-5(five being the most effective).

	-SOCIAL/BEHAVIORAL ACCOMMODATIONS-	**Beginning to End Date Strategy Utilized**	**Times Used Per Week**	**Effectiveness Rating**
	Discuss behavioral issues privately with student			
	Facilitate peer interactions			

CST Referral Form/Student Name:_____

	Communicate with supportive personnel (i.e. behavior specialist)			
	Present alternatives to negative behavior			
	Develop Social Stories			
	Desensitize student to anxiety causing events			
	Monitor for overload, excess stimuli			
	Identify triggers of concerning behaviors			
	Help student manage triggers			
	Develop signal for when break is needed			
	Give student choices			
	Maintain communication with home			
	Provide positive reinforcement			
	Provide behavior consistent praise			
	Provide counseling			
	Others:			

Parent involvement and contact:

Date	**Contact** (phone/person)	**Concern** (be specific)	**Outcome** (specify accommodations/ modifications and responsible parties to implement)	**Effectiveness** (provide detailed implementation of strategies in conjunction with the parent for duration of no less than three weeks.)

Teacher Signature: _____ Date Completed:_____

Principal Signature: _____ Date Received:_____ Accepted/Denied

Timeline Monitoring:

Director of Special Services Signature:_____ Date Received:_____

Initial Planning Meeting to be scheduled by :_____ (holidays are excluded when calculating the 20 day requirement)