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
All Information must be completed

IDENTIFYING INFORMATION

(Please obtain this information 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**___________________________________

CURRENT SUPPORTIVE SERVICES

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

Y N I&RS **(If this is a teacher referral and you have not referred this student to I & R S for support, you may begin that process first)**
Y N I&RS Initial Meeting Date :_________________(Attach paperwork)
Y N I&RS Follow-up meeting Date: ________________ (Attach paperwork)
Y N ELL (___x weekly/___minutes)
Y N Speech ___x weekly ___minutes ___individual ___small group
Y N School Counselor ___Regularly ___As needed
Y N Basic Skills ___Math (__x weekly/__minutes)
___Reading (__x weekly/__minutes)
___Writing (__x weekly/__minutes)
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 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:______________________

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.

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HEALTH INFORMATION SUMMARY :(Please have the nurse complete this section)

	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.)

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

CST Referral Form/Student Name:______________________

Basis for Referral

Academic concerns: (Please complete this section for all referrals)

____
____
____

Academic Status and Progress (K-8):

Current Grade_____			
Schoolwide Assessment	**Fall**	**Winter**	**Spring**
DIBELS			
ELA Benchmark (Include Fluency,Comprehension, Writing, Accuracy Score)			
Writing Benchmark			
Math Benchmark			
Running Records			
WIDA ACCESS Proficiency Score			
Last school year/Grade_____			
Schoolwide Assessment	**Fall**	**Winter**	**Spring**
DIBELS			
ELA Benchmark (Include Fluency,Comprehension, Writing, Accuracy Score)			
Writing Benchmark			
Math Benchmark			
Running Records			
WIDA ACCESS Proficiency Score			

Schoolwide Assessment	**Fall**	**Spring**
MATH		
Unit Test		
MAP Test		
ELA		
Unit Test		
MAP Test		
Read 180		
WIDA ACCESS Proficiency Score		
Schoolwide Assessment	**Fall**	**Spring**
MATH		
Unit Test		
MAP Test		
ELA		
Unit Test		
MAP Test		
Read 180		
WIDA ACCESS Proficiency Score		

CST Referral Form/Student Name:______________________

Academic/Classroom Performance:

___Working below grade expectation
List:_________________________
___Drop in grades, lower achievement
___ Prefers to work alone
___Does not ask for help when needed
___Does not complete classwork
___ Short attention span/easily distracted
___ Poor short-term memory
___Gives up easily
___ Lacks desire to do well in school
___Does not appear to apply self
___Homework concerns
___ Other (Specify):____

Prior Academic 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).

	-----**CONTENT/MATERIAL ACCOMMODATIONS/MODIFICATIONS-----**	**Beginning to End Date Strategy Utilized**	**Times Used Per Week**	**Effectiveness Rating (1 - 5)**
	Provide copy of class notes			
	Adjust number of items student is expected to complete			
	Limit number of items student is expected to learn at one time			
	Allow extra time for task completion			
	Allow verbal rather than written responses			
	Pre-teach new vocabulary			
	Modify curriculum content based on student's ability level			
	Reduce readability level of materials			
	Use of calculator			
	Use of a math grid			
	Modified homework assignments (modify content, modify amount, as appropriate)			
	---ORGANIZATIONAL ACCOMMODATIONS---	**Beginning to End Date Strategy Utilized**	**Times Used Per Week**	**Effectiveness Rating (1 - 5)**
	Assistance with organization of planner/schedule			
	Use a consistent daily routine			
	Break down tasks into manageable units			
	Use of checklists			
	Provide a visual schedule			
	Provide a highly structured, predictable learning environment			
	Provide timelines for work completion			
	Different colored folders for different subjects			
	Provide organizers/study guides			

CST Referral Form/Student Name:______________________

	---INSTRUCTIONAL ACCOMMODATIONS---	**Beginning to End Date Strategy Utilized**	**Times Used Per Week**	**Effectiveness Rating (1 - 5)**
	Frequently check for understanding			
	Color code important information			
	Emphasize use of visual aids			
	Simplify task directions			
	Provide hands-on learning activities			
	Provide modeling			
	Provide guided instruction			
	Place student in cooperative learning groups			
	Provide Choice Menus			
	Modify pace of instruction to allow additional processing time			
	---INSTRUCTIONAL ACCOMMODATIONS---	**Beginning to End Date Strategy Utilized**	**Times Used Per Week**	**Effectiveness Rating (1 - 5)**
	Provide small group instruction			
	Encourage use of mnemonic devices			
	Provide oral as well as written instructions/directions			
	Reinforce visual directions with verbal cues			
	Help to develop metacognitive skills (self-talk and self-correction)			
	Directions repeated, clarified or reworded			
	Provide individualized instruction			
	Provide multi-sensory instruction			
	Reteach materials, when needed			
	Limit new concepts taught per instructional period			
	Have student demonstrate understanding of instructions/task before beginning assignment			
	Teach student learning strategies			
	Teach specific memory cues and devices			
	Utilize peer teaching			
	Use interests to increase motivation			
	Use marker (e.g. index card, ruler) for visual tracking			
	--ASSESSMENT ACCOMMODATIONS/ MODIFICATIONS--	**Beginning to End Date Strategy Utilized**	**Times Used Per Week**	**Effectiveness Rating (1 - 5)**
	Additional time to complete classroom tests/quizzes			
	If possible, avoid more than one test on the same day			
	Provide larger white work space on quizzes and tests, particularly in math			
	Modify the number of choices on tests/quizzes			
	Allow for oral rather than written responses on tests			
	Allow for oral follow-up for student to expand on written response			
	Provide option for alternative assessments			
	Provide a word bank for fill-in-the blank tests			

CST Referral Form/Student Name:______________________

	Read test aloud			
	ACCOMMODATIONS FOR ATTENTION/FOCUS	**Beginning to End Date Strategy Utilized**	**Times Used Per Week**	**Effectiveness Rating (1 - 5)**
	Seat student near front of room			
	Preferential seating			
	Monitor on-task performance			
	Arrange private signal to cue student to off-task behavior			
	Establish and maintain eye contact when giving oral directions			
	Stand in proximity to student to focus attention			
	Provide short breaks when refocusing is needed			
	Use study carrel			
	Arrange physical layout to limit distractions			
	Seat student near positive role model			
	Frequently ask questions to engage student			
	-WRITTEN LANGUAGE ACCOMMODATIONS-	**Beginning to End Date Strategy Utilized**	**Times Used Per Week**	**Effectiveness Rating (1 - 5)**
	Include brainstorming as a pre-writing activity			
	Teach the writing process			
	Edit written work with teacher guidance			
	Allow use of word processor			
	Use graphic organizers			
	-ELL ACCOMMODATIONS-	**Beginning to End Date Strategy Utilized**	**Times Used Per Week**	**Effectiveness Rating (1 - 5)**
	Content Reading Strategies			
	Vocabulary Development			
	Higher Order Questioning/Thinking Skills			
	TPTs (Total Participation Techniques)			
	Scaffolding Instruction			
	Fluency Building Activities/Strategies			

<u>Behavioral and Social Concerns:</u>

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

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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
___Obscene language, gestures
___ Noisy, boisterous at inappropriate times
___ Lack of impulse control
___ Highly active

CST Referral Form/Student Name:______________________

___Sudden outbursts of anger
___Other:_________________________________
___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
___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
___ Other social behavior of concern: ____

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 (1 - 5)**
	Discuss behavioral issues privately with student			
	Facilitate peer interactions			
	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			
	Model and role play social skills			
	Provide counseling			
	Use social skills group to teach skills and provide feedback			

CST Referral Form/Student Name:______________________

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.)

Nurse Signature: ______________________ Date: ________

Guidance Counselor: ____________________ Date: ________

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)