

Student Name: _____

STUDENT ASSISTANCE PROGRAM REFERRAL FORM
COORDINATOR CHECKLIST

(Check off to ensure that all information and materials have been gathered before the meeting)

- Referral form(s) Date received: _____
- Medical history
- Cumulative folder brought to meeting
- Copy of current grades / progress reports/ test scores
- #1 Parent / guardian notified of referral to SAP date: _____
- #2 Parent / guardian notified of referral to SAP date: _____
- Student interview notes (as applicable)
- Parent / guardian interview notes (as applicable)
- Current attendance
- Previous year attendance (if applicable)
- Language Dominance (if applicable)
- Discipline report (if applicable)
- External services (as applicable)
- Previously referred to SAP Date: _____
- Other pertinent data:

- Date of action plan: _____
- Review Date: _____
- Review Date: _____
- Review Date: _____
- Review Date: _____

Student Name: _____

STUDENT ASSISTANCE PROGRAM REFERRAL FORM

Date: _____

Teacher: _____

DOB: _____ Gender: _____ Grade: _____

#1 Parent/Guardian Name: _____

Home Phone#: _____ Work #: _____ Cell #: _____

Address: _____

#2 Parent/Guardian Name: _____

Home Phone#: _____ Work #: _____ Cell #: _____

Address: _____

Referred by: _____

#1 Parent contacted: Date: _____ Method: Phone ___ Email ___ Letter ___ Conference ___

#2 Parent contacted: Date: _____ Method: Phone ___ Email ___ Letter ___ Conference ___

New to District: Yes _____ No _____

Previous District/School attended: _____

Areas of Concern:

Academic Performance Attendance Classroom Conduct Other Behaviors

Health/Physical Concerns Organization PT/OT/Speech

Supporting Information from Review of Cumulative Folder

Date Reviewed _____ Reviewed by _____

List pertinent information:

Student Name: _____

Student Strengths

Please check off areas of strength and **add specific information** about who or what is involved next to the item. Add any other strength not already listed in open spaces.

<u>Internal</u>			<u>External</u> (from school, home, peers, etc.)		
1.	<input type="checkbox"/>	Academic competence	18.	<input type="checkbox"/>	Care & support from others:
2.	<input type="checkbox"/>	Commitment to learning	19.	<input type="checkbox"/>	High positive expectations from others:
3.	<input type="checkbox"/>	Positive values (integrity, honesty, responsibility, justice)	20.	<input type="checkbox"/>	Clear boundaries from others:
4.	<input type="checkbox"/>	Positive identity	21.	<input type="checkbox"/>	Opportunities to feel likeable / loveable:
5.	<input type="checkbox"/>	Social competence (flexibility, empathy, caring, sense of humor, etc.)	22.	<input type="checkbox"/>	Opportunities to feel capable:
6.	<input type="checkbox"/>	Problem Solving skills (imagination, planning, resourcefulness, etc.)	23.	<input type="checkbox"/>	Opportunities to feel important:
7.	<input type="checkbox"/>	Communication skills	24.	<input type="checkbox"/>	Opportunities to use skills and knowledge:
8.	<input type="checkbox"/>	Anger management skills	25.	<input type="checkbox"/>	Reinforcement for effort and achievement:
9.	<input type="checkbox"/>	Autonomy (self-discipline, resistance skills, initiative, etc.)	26.	<input type="checkbox"/>	Bonding to positive adults:
10.	<input type="checkbox"/>	Sense of purpose and future goals	27.	<input type="checkbox"/>	Bonding to positive peers:
11.	<input type="checkbox"/>	Takes healthy risks	28.	<input type="checkbox"/>	Community / school service:
12.	<input type="checkbox"/>	Healthy personal rules (realistic, flexible)	29.	<input type="checkbox"/>	Creative activities:
13.	<input type="checkbox"/>	Creativity:	30.	<input type="checkbox"/>	Youth activities (hobbies, sports, clubs):
14.	<input type="checkbox"/>	Leadership:	31.	<input type="checkbox"/>	Other:
15.	<input type="checkbox"/>	Interests:	Strengths in Special Areas (to be completed after consultation with specialists) List the number of each strength and any comments.		
16.	<input type="checkbox"/>	Talents:	Art:		
17.	<input type="checkbox"/>	Other:	Music:		
			Physical Education:		
			Science Lab:		
			Technology:		

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Behaviors of Concern

Please check any behaviors that you have witnessed and are concerned about that have occurred several times or have become a pattern.

Academic Performance		Organizational Concerns (continued)	
1.	<input type="checkbox"/> Class work not handed in	40.	<input type="checkbox"/> Inconsistent use of agenda
2.	<input type="checkbox"/> Decline in quality of work	41.	<input type="checkbox"/> Lack of neatness
3.	<input type="checkbox"/> Failing class/classes	42.	<input type="checkbox"/> Little perception of time needed to complete task
4.	<input type="checkbox"/> Homework not handed in	43.	<input type="checkbox"/> Loses materials frequently
5.	<input type="checkbox"/> In danger of retention	44.	<input type="checkbox"/> Unable to start/finish a task
6.	<input type="checkbox"/> Inconsistent effort / lack of effort	Other Behaviors	
7.	<input type="checkbox"/> Lack of preparation	45.	<input type="checkbox"/> Aggressive (physical, verbal, relational)
Classroom Conduct		46.	<input type="checkbox"/> Alibis, excuses
8.	<input type="checkbox"/> Apathy toward school / learning	47.	<input type="checkbox"/> Blames others
9.	<input type="checkbox"/> Asks for inappropriate amount of help	48.	<input type="checkbox"/> Change in peer group / friends
10.	<input type="checkbox"/> Difficulty with remembering	49.	<input type="checkbox"/> Changes in expression of emotions
11.	<input type="checkbox"/> Disrupts the class	50.	<input type="checkbox"/> Constant talking
12.	<input type="checkbox"/> Frequent absences/poor attendance	51.	<input type="checkbox"/> Defensive, argumentative, short-tempered
13.	<input type="checkbox"/> Frequent tardiness	52.	<input type="checkbox"/> Difficulty with changes in routine
14.	<input type="checkbox"/> Frequently asks to be excused from class	53.	<input type="checkbox"/> Does not comply with school rules, policies
15.	<input type="checkbox"/> Frequently needs discipline	54.	<input type="checkbox"/> Drug/ alcohol messages, drawings, jewelry
16.	<input type="checkbox"/> Inattentive/daydreams	55.	<input type="checkbox"/> Erratic behavior / emotions
17.	<input type="checkbox"/> Lack of focus & concentration / easily distracted	56.	<input type="checkbox"/> Expects perfection from self
18.	<input type="checkbox"/> Needs help often	57.	<input type="checkbox"/> Intimidates, harasses, excludes others
19.	<input type="checkbox"/> Nervous / fidgety behavior	58.	<input type="checkbox"/> Isolated, has few friends
20.	<input type="checkbox"/> Skipping class	59.	<input type="checkbox"/> Lack of concern for appearance/hygiene
21.	<input type="checkbox"/> Sleeping in class	60.	<input type="checkbox"/> Lacks confidence
22.	<input type="checkbox"/> Socializes/talks during class	61.	<input type="checkbox"/> Lies
23.	<input type="checkbox"/> Use of pacifiers/ lollipops, etc.	62.	<input type="checkbox"/> Obscene/offensive language, gestures
Health/ Physical Concerns		63.	<input type="checkbox"/> Other students express concern
24.	<input type="checkbox"/> Bloodshot / glassy eyes	64.	<input type="checkbox"/> Possesses large amounts of cash
25.	<input type="checkbox"/> Bruises/ marks/ self mutilation	65.	<input type="checkbox"/> Secretive
26.	<input type="checkbox"/> Changes in appearance		<input type="checkbox"/> Seems sad, unhappy, crying
27.	<input type="checkbox"/> Change in eating / sleeping patterns	66.	<input type="checkbox"/> Talks freely/ brags about inappropriate behaviors
28.	<input type="checkbox"/> Constant runny nose or cough	67.	<input type="checkbox"/> Talks frequently about violence
29.	<input type="checkbox"/> Detected odor of alcohol or marijuana	68.	<input type="checkbox"/> Talks, writes, draws about death
30.	<input type="checkbox"/> Dilated / shrunken pupils	69.	<input type="checkbox"/> Unwilling to take risks
31.	<input type="checkbox"/> Forgets glasses	70.	<input type="checkbox"/> Withdrawn
32.	<input type="checkbox"/> Frequent illness	Other	
33.	<input type="checkbox"/> Gross/fine motor coordination difficulties	71.	<input type="checkbox"/>
34.	<input type="checkbox"/> Lack of energy	Special Areas (to be completed after consultation with specialists) List the number of each behavior of concern: Art: Music: PE: Science Lab: Technology:	
35.	<input type="checkbox"/> Speech/language difficulties		
36.	<input type="checkbox"/> Stumbles /slurred speech		
37.	<input type="checkbox"/> Weight loss / gain		
Organizational Concerns			
38.	<input type="checkbox"/> Difficulty completing long term tasks, prioritizing, multi-tasking		
39.	<input type="checkbox"/> Difficulty locating/organizing materials	Other:	

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Classroom Interventions Made Prior to SAP Referral

Classroom Interventions/ Strategies	What was done/ Information received (as applicable)	Duration /Dates	Outcome	* DOS
<input type="checkbox"/> Talked with / interviewed student				
<input type="checkbox"/> Talked with / interviewed parent /guardian				
<input type="checkbox"/> Identified & built on student strengths				
<input type="checkbox"/> Identified student deficits & built skills				
<input type="checkbox"/> Identified student's preferred learning styles				
<input type="checkbox"/> Adapted teaching style, methods, materials, assignments, etc.				
<input type="checkbox"/> Identified context in which behavior of concern occurs				
<input type="checkbox"/> Consulted professional resources (PRIM, etc.)				
<input type="checkbox"/> Created checklist/plan/chart/ reward system (academic, behavioral, social)				
<input type="checkbox"/> Made classroom accommodations				
<input type="checkbox"/> Referred to in-school services/programs/strategies				
<input type="checkbox"/> Had student tutor or help younger students				
<input type="checkbox"/> Recommended community services/programs				
<input type="checkbox"/> Consulted with colleagues (list name)				
<input type="checkbox"/> Other				

* Degree of Success	#	Minimal progress / Emerging skill	3
Successful Intervention / Sustaining skills	1	No observable progress	4
Showing Some Progress/ Skills developing	2	Not Applicable	5

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STUDENT ASSISTANCE PROGRAM REFERRAL FORM
MEDICAL HISTORY

(To be completed by School Nurse)

Date of last vision test: ____ Findings: _____

Medical Referral made: ____ Yes ____ No

Date of last hearing test ____ Findings: _____

Medical Referral made: ____ Yes ____ No

Date of last physical: _____ Findings: _____

Significant Medical Conditions (asthma, diabetes, allergies, heart problems etc.)

Medications / Medications Administered in School

Other Comments: i.e. frequency / pattern of visits (Same time every day? Same day each week?), non-specific complaints, medical / hygiene concerns etc.

Medical release on file: ____ Yes ____ No

Other releases on file: ____ Yes ____ No

Please list: