Arlington Public Schools

STUDENT SUPPORT REFERRAL K-12 FORM

Student Name	Student ID	Date of Birth
School	Grade	Counselor (secondary)
Parent/Guardian Name(s)	Current 504 ☐ Yes ☐ No Has the student received Special Education Before: ☐ Yes ☐ No	
Phone	Gifted Identification ☐ Yes or ☐ No Area Identified:	Health Plan / Alert ☐ Yes or ☐ No
Name of Referring Source	Relationship	Date of Referral

Translator Required: ☐ Yes ☐ No If yes, language required: _____

Strengths:

Referral Concerns: Please describe the concern(s) affecting the student's performance in school and provide any supporting data. What do you want the student to do that they are not currently doing? (Attach pages if needed)

Have these concerns been discussed within a CLT or with other colleagues in the building to problem solve?
☐ Yes ☐ No

English Learner ☐ Yes or ☐ No Native Language: _____Program Placement____

Length of Program Placement _____

If yes, WIDA ACCESS scores: Listening ___, Speaking ___, Reading ___, Writing ___, and Overall WIDA level: ___

If yes, attach the **EL Protocol**

Have the parents/guardians been contacted previously about related concerns? If so, please provide details.

If yes, please provide details and date/s contact was made (or attach contact log).

SUPPORTS: It is the expectation that school staff have implemented supports prior to a referral and have progress data documented.

Accommodations tried (if applicable) (i.e. cues for attention, small group)	**Outcomes/Student Progress:**

Intervention: (*Attach pertinent information for interventions such as copies of interventions plans from Synergy or other sources, data on progress and outcomes)*

Academic Interventions Implemented (i.e Orton Gillingham)	**Frequency and Duration (i.e 6-8 weeks 4x a week)**	**Outcomes/Student Progress (be specific – what does the data show?)**

Behavioral/Social Emotional Interventions Implemented (i.e Zones of Regulation)	**Frequency and Duration (i.e 6-8 weeks 4x a week)**	**Outcomes/Student Progress**

List any interventions provided by parents/guardians (e.g., tutoring, private therapy or evaluation, medication, etc.)

Please attach relevant assessment data (SOL, PALS, Power Tests, writing samples, etc.).

Has the student had a previous IAT/SST meeting? If so, please provide the date, reason for referral and outcome of the meeting or attach previous referral forms.

Teacher(s)/Staff: Indicate a rating of this student's performance on a scale from 1 to 5

	Unsatisfactory		Average		Excellent
Classwork	1	2	3	4	5
Homework	1	2	3	4	5
Test Performance	1	2	3	4	5
Oral Expression	1	2	3	4	5
Written Expression	1	2	3	4	5
Attention	1	2	3	4	5
Organization	1	2	3	4	5
Attendance	1	2	3	4	5
Following Directions	1	2	3	4	5
Interpersonal Relations	1	2	3	4	5

Does the child have a diagnosis of any kind?

School Attendance

Years in APS _____ Current Year _____ Absences_____ Tardies_____
Does the student have an attendance plan? ☐ Yes ☐ No
Other Attendance Information: (i.e whole day attendance or period attendance)

OFFICE USE ONLY

Date referral form received _____ Received by: _____
Date meeting scheduled _____