

Baltimore County Public Schools

REFERRAL TO STUDENT SUPPORT TEAM FORM

Date:

Student's Name:

DOB:

Grade:

School:

Parents/Guardians:

Phone:

Person Completing Referral Form:

Parent Contacts (Indicate Dates):

Phone:

Conference:

Home Visit Date(s) by PPW/SW:

Reason(s) for request *(Be specific; list concerns in behavioral terms.):*

Screening Data *(As part of the referral to Student Support Team, please complete data below.)*

Give an explanation of strategies/interventions that have been attempted by parents/guardians, administrators, teachers, resource teachers, school counselors, school nurses, school social workers, school psychologists, PPWs, and other school staff.
(Strategies, interventions should be specific to the individual student.)

Strategy	How Long Attempted?	Result

List Strengths (e.g., *When is the concern not present? When is it less severe? When does it happen less frequently?*)

List Current Levels of Performance: (Please attach a copy of student's current report card)

- | | | | |
|--------------------------|--|--|--|
| Reading: | <input type="checkbox"/> Above Grade Level | <input type="checkbox"/> On Grade Level | <input type="checkbox"/> Below Grade Level |
| Written Language: | <input type="checkbox"/> Above Grade Level | <input type="checkbox"/> On Grade Level | <input type="checkbox"/> Below Grade Level |
| Mathematics: | <input type="checkbox"/> Above Grade Level | <input type="checkbox"/> On Grade Level | <input type="checkbox"/> Below Grade Level |
| Social/Emotional: | <input type="checkbox"/> No Concerns | <input type="checkbox"/> Area of Concern | |
| Behavior: | <input type="checkbox"/> No Concerns | <input type="checkbox"/> Area of Concern | |

What would you like the student to be able to do that he/she does not do presently? (*What are your goals for student? What outcomes would you like to see?*)

Additional Comments:

This form is to be presented to the Chair of the Student Support Team a week prior to the next scheduled meeting.