Ashford School

Student Intervention Team (SIT)

Initial Referral Form

Student Name: _____

D.O.B:_____

Grade: _____

Teacher: _____

Date: _____

<u>Please select ONE area of concern and ONE-TWO corresponding skills:</u>

Reading/Writing/Language:

Decoding	Fluency	Letter formation/spacing
Vocabulary	Comprehension	Organization
Spelling	Writing Conventions	

Other: _____

Math:

Number awareness	Facts	Problem Solving
Counting	Fluency	

Other:_____

Behavior:

Attention	Social	Emotional
Flexibility	Rules/Routines	Sensory

Other:_____

Tier 1: Classroom Interventions:

Description:	**Progress** (limited, moderate, significant)
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Tier II: Specialist Interventions (Can include consultation):

Who?	**What?**	**How often?**	**How long?**
(ex. School Psychologist)	(ex. Social Skills small group)	(ex. 1xweekly for 25 min)	(ex. 6 weeks)

Assessment Data (If applicable):

Assessment Type:	**Score:**
(ex: STAR Reading)	(ex: G.E.= 2.5)

Other Pertinent Information:

(Ex: primary language, health, vision, hearing, retention, attendance, etc.)

Please describe student strengths/interests:

Has the student's parent(s) been notified of your concerns? Y or N

Has the student's parent(s) been notified of this referral? Y or N

Person(s) Completing Form:

_____

_____

_____