

# Pre-Referral Request for Problem Solving

Student: \_\_\_\_\_ School: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Date: \_\_\_\_\_ Grade: \_\_\_\_\_ Person Completing This Form: \_\_\_\_\_  
Parents or Guardians: \_\_\_\_\_

## Background Information

### Medical History:

- Generally Healthy    Allergies    Ear Infections    Head Injury    Seizures    Orthopedic Impairment  
 Takes Medication (what? why?) \_\_\_\_\_  
 Has Known Health Condition (describe) \_\_\_\_\_  
 Vision Passed (Date: \_\_\_\_\_)    Vision Failed (Date: \_\_\_\_\_)    Hearing Passed (Date: \_\_\_\_\_)    Hearing Failed (Date: \_\_\_\_\_)

### School History:

- Attendance:  Good    Often Absent ( \_\_\_\_\_ times/week)    Often Tardy ( \_\_\_\_\_ times/week)    Truant ( \_\_\_\_\_ times/week)  
Student has attended \_\_\_\_\_ schools since beginning school. Student has been at this school for how long? \_\_\_\_\_  
Student has been retained?  No    Yes What grade was this student retained? Why? \_\_\_\_\_  
Student is passing all subjects?  No    Yes If not, which subject(s) is student failing? \_\_\_\_\_  
 Outside evaluation(s) in file    Previous Special Education evaluation(s) in file    Previous Special Education referral(s)  
Student has received disciplinary action for inappropriate behavior in school?  Yes    No  
If yes, please summarize the general type of infractions, where they occur, and the frequency: \_\_\_\_\_

### Other Programs, Agencies, and Services:

- Title 1    Gifted and Talented    Special Education Preschool    Juvenile Justice (Youth Court)    YBGR Case Management  
 STEP Early Intervention    Family Services    Community Therapist/Counselor    School Counselor    Head Start  
 Vocational Rehabilitation    Private School    Outside Tutoring    \_\_\_\_\_

## Specific Concerns

### Areas of Concern: (Check one or more)

- Oral Expression    Listening Comprehension    Written Expression    Basic Reading Skill    Reading Comprehension  
 Math Calculation    Math Reasoning    Reading Fluency    Reading Decoding    Health    Cognitive Ability  
 Physical Development    Behavior    Emotional Adjustment    Language    Motor Abilities    Speech    Vision

### Reasons for Concerns: (Check all that apply)

- Early Knowledge:  Body Parts    Colors    Counting    Shapes    Letters    Concepts (in, under, before, etc.)  
Self-Help:  Dressing    Toilet Training    Fasteners (buttons, zippers)    Feeding Self    Table Skills/Utensils  
Academic Skills:  Trouble with multi-step procedures    Difficulty with spoken directions    Difficulty with written directions  
 Work of poor quality    Forgets previously learned skills    Lack of homework completion    Fails to complete class work  
 Slow to catch on    Fails to turn work in  
Behavior:  Inattentive    Temper    Cries/Tearful    Disorganized    Defiant    Impulsive    Swearing    Overactive  
 Difficulty work/play with peers    Breaks important rules    Stomachaches/Headaches    Poor ability to concentrate  
 Lack of participation    Seeks negative attention    Low energy level    Obsessive/Compulsive    Easily frustrated  
 Sadness/Depression    Anxiousness/Worrying    Irritable/Moody    Physical Aggression    Verbal Aggression  
Speech and Language:  Omits sounds    Word finding problems    Limited speaking vocabulary    Difficulty classifying objects  
 Substitutes sounds    Difficulty producing sounds    Frequent grammatical errors    Difficulty discriminating sounds  
 Poor voice quality    Dysfluent speech    Incomplete sentences    Stutters    Unintelligible    Does not speak  
Motor:  Running, Jumping    Catching, Throwing    Balance    Coordination    Poor pencil/scissor use    Poor handwriting

- 1) What is the main problem? (Please be specific)
  
- 2) Describe what you would like the student to be able to do.
  
- 3) Describe what the student is currently doing. (Please be specific)
  
- 4) Describe which specific research-based programs or strategies have been used to address the problem:

Dates (begin and end)	Program/Strategy	Frequency	Results

(Attach Documentation Sheets if Necessary)

5) Have the student's parents been contacted:  No  Yes Date: \_\_\_\_\_

Response from parents regarding the concern: \_\_\_\_\_

6) What would you like the Pre-Referral Team to assist you with specifically?

---

### Pre-Referral Team Meeting Recommendations

Date of Pre-Referral Team Meeting: \_\_\_\_\_

General Recommendations from the Team:

Recommended Specific Research-Based Programs or Strategies to Begin Implementing:

When will these recommendations/interventions be reviewed by the Pre-Referral Team? \_\_\_\_\_

_____ Parent	_____ Parent
_____ Teacher	_____ Teacher
_____ Teacher	_____ Spec. Ed. Teacher
_____ Administrator	_____ Counselor
_____ School Psychologist	_____ Other