CST Referral Form – Burlington County Institute of Technology

Student/Parent Guardian Information

Name_____ Grade _____ Shop Area _____
Date of Birth _____ Date of Referral _____
Parent/Guardian Name_____
___Parent ___Guardian ___Foster Parent Does the parent have joint custody? ___Y or ___N
Parent Address: _____
Telephone Number_____ (Home or Cell)
Name of person completing form_____
Who made the referral?_____

Reason for Referral

___ Academic Concerns ___ Behavioral/Emotional*
___ Speech Language* ___ Other (Please specify)_____

Have the Parents been contacted regarding these concerns? ____Yes ____ No
How were they contacted? Phone: _____ Conference: _____ Email: _____ Letter: _____

Student Background Information (Cumulative Folder Review)

Current District	**Previous Schools/Services (504 Plan, I&RS Evaluations)**	**Report Card Review/ Transcript review**
Grade 9		
Grade 10		
Grade 11		
Grade 12		

Student's strengths:

Student's weaknesses:

Does the student see a therapist outside of school? _____ Yes _____ No

If Yes, please list person's name, number and credentials

_____

Does student take medication? ___ Yes ____ No

Please list the medications_____

PLEASE CHECK AREAS OF CONCERN

Physical/Emotional Health

_____ Has a medical diagnosis
Please specify_____
_____ Medicated (please specify)
_____
_____ Frequent illness
_____ Vision
_____ Hearing
_____ Physical stamina
_____ Fine motor
_____ Gross motor
_____ Attention Issues
_____ Self care
_____ Background of emotional trauma

Emotional health concerns

___ Anxiety ___ Depression
___ Anger ___ Coping Skills
___ Other ___ Aggression

Ability/Processing/Language

____ Possible low cognitive ability
____ Retaining information
____ Retrieving information
____ Rate of processing
____ Work completion
____ Following directions
____ Producing grade level work
____ Oral comprehension
____ Vocabulary
____ Oral expression
____ Oral grammar
____ Articulation

Other Factors

_____ Needs an unusual amount of attention
_____ Friendship concerns
_____ Shows signs of immaturity
_____ Poor social skills
_____ Student is disorganized
_____ Uncomfortable with noises, lights or clothing

Summary of Concerns:

Case Manager to Be Assigned: _____

Date: _____

Pre-Referral Intervention Documentation-Health Related Information

Student Name:_____ Grade:_____ Age:_____

Weight:_____ Height:_____

Grade 9 _____

Grade 10 _____

Grade 11 _____

Grade 12 _____

Audiometric Screening:

Date: _____ Results: _____

Vision Screening:

Date: _____ Results: _____

Is the student taking any medications?

Are there any known medical problems?

Do you have any current concerns about this student's physical health?

Does the student's medical condition cause them to be absent or late to school?