Newfoundland Labrador

Assessment Referral to Service Delivery Team

Referral Tracking Number

B	R	D.	S	C	H.	Y	R.	S	T	I	D

Entered by Student Support Services Team at the SST Meeting

Name: _____ Gender: _____

D.O.B.: (yyyy/mm/dd) _____ MCP: _____

Parent/Guardian: _____ Phone Number: _____

School: _____ School Telephone: _____

Teacher: _____ Grade: _____

Principal: _____ Guidance Counsellor: _____

Status

Is this a ***Reassessment***? ☐ No ☐ Yes

If yes, please provide previous RTS#

B	R	D.	S	C	H.	Y	R.	S	T	I	D

Reason for Reassessment:

_____

Indicate Current Programming (√ as many as apply):

☐ Prescribed
☐ Accommodations
☐ Modified Prescribed
☐ Alternate Program
☐ Alternate Course
☐ Alternate (Functional) Curriculum

Other Personnel Involved: _____

Does the student have an IEP? ☐ Yes ☐ No ***An ISSP?*** ☐ Yes ☐ No

Hearing/Vision Check

Attach Most Recent Results: ☐ Hearing ☐ Vision

(Teacher obtains from parent/guardian)

Referral Reason

What is the main area of concern?

☐ Academic – Specify _____
☐ Behaviour – Specify _____
☐ Social/Emotional – Specify _____
☐ Speech Language – Specify _____
☐ Others – Specify _____

What questions would you like answered as a result of this referral?

_____

_____

_____

Teacher Signature: _____ Referral date: _____

Authorized by the Department of Education
September 2010