

CAP Team

W.R. Croman Student Assistance Program

Referral Form

Student Name _____

Referring Person _____ Date _____

Grade ___K ___1 ___2

What are your concerns?

___ Academic ___ Social/Emotional ___ Medical ___ Behavioral

Give a brief description of your concerns.

Have you contacted the parents? _____ If yes, explain the outcome:

What interventions are already in place and utilized? (i.e. academic interventions, seating changes, conference with parents, etc.)

What utilized interventions have worked?

See other side

CAP Team

W.R. Croman Student Assistance Program Referral Form (Page 2)

Please check any behaviors you have witnessed:

- | | |
|--|---|
| <input type="checkbox"/> Decreased or low class participation | <input type="checkbox"/> Changes in activities |
| <input type="checkbox"/> Easily distracted or troubles concentrating | <input type="checkbox"/> Increased irritability |
| <input type="checkbox"/> Decrease in the quality of work | <input type="checkbox"/> Copying |
| <input type="checkbox"/> Poor short-term or long-term memory | <input type="checkbox"/> Changes in friends |
| <input type="checkbox"/> Low frustration tolerance | <input type="checkbox"/> Does not follow teacher instructions |
| <input type="checkbox"/> Change in attendance/tardiness | <input type="checkbox"/> Drastic changes in appearance |
| <input type="checkbox"/> Frequent requests to leave the room | <input type="checkbox"/> Frequent request to visit the nurse |
| <input type="checkbox"/> Outbursts of anger | <input type="checkbox"/> Lying |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Fighting |
| <input type="checkbox"/> Is argumentative | <input type="checkbox"/> Change in energy level |

Other: